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SOCIAL ADJUSTMENT OF PATIENTS IN THE COMMUNITY THREE YEARS AFTER COMMITMENT TO THE BOSTON PSYCHOPATHIC HOSPITAL[1]

J. SANBOURNE BOCKOVEN, M.D.,* ANNA R. PANDISCIO,† AND HARRY C. SOLOMON, M.D.‡

DURING recent years at the Boston Psychopathic Hospital, somatic treatments, milieu therapy, psychotherapy, and psychiatric social work have been accompanied by a large increase in the proportion of committed psychotic patients returned to the community. Further development and wider application of these treatment methods at this and other mental hospitals can reasonably be expected to result in the discharge of nine-tenths of the patients committed to mental hospitals for functional psychosis. This prospect makes imperative a shift of psychiatric interest from custodial care to the question of the ex-patient's social adjustment in the community.

The study reported here centers entirely on the social adjustment of the ex-committed patient. It does not deal with the ex-patient's mental status. The subjects of the study were interviewed by an investigator who was not especially trained in psychiatric interviewing but whose background was largely sociological. The method used for ascertaining the patient's social adjustment was developed through the collabora-

[1] The authors wish to thank Miss Esther Cook, head social worker at the Boston Psychopathic Hospital, for her helpful criticism during the development of this paper, and Mrs. Edna Barrabee, M.S., for her suggestions and valuable instructions in the administering and scoring of the Barrabee-Finesinger Social Adjustment Scale.

* Assistant in psychiatry, Harvard Medical School; assistant physician, Department of Research, Boston Psychopathic Hospital.

† Research assistant, Department of Research, Boston Psychopathic Hospital.

‡ Professor of psychiatry, Harvard Medical School; medical director, Boston Psychopathic Hospital.

tion of a sociologist, a psychiatric social worker, and a psychiatrist. The goal of this method, and of this study as a whole, was to determine the ex-patient's performance as a member of the community. No distinction was made between ex-patients who were asymptomatic in a psychiatric sense and those who had symptoms. As such, the results of this study do not indicate the results of treatment in the strict medical sense of the term. They do, however, reflect in some measure the results of hospitalization as a learning experience in the art of human relations.

Method

The problem of evaluating the social adjustment of ex-patients without injecting the usual psychiatric preoccupation with diagnosis and symptomatology was solved by adopting a method which had already proved its usefulness in evaluating the social adjustment of patients treated for cardiac illnesses. This method—the Barrabee-Finesinger Social Adjustment Scale [2]—was particularly advantageous since two of its authors were available for consultation and instruction in its use.

Information was obtained from the patients by direct interviews which took an hour to an hour and a half. The interview covered:

Occupational Adjustment.[3] Each patient was asked to give an account of his work history since his discharge from the hospital, such as how many jobs he may have had, reasons for leaving previous jobs, how well he got along with employer and other employees, his ability to work at the job, his ability to work a full day, his need to take days off from work, and his degree of satisfaction with his job.

Economic Adjustment. This category was based upon financial independence of the patient according to the rate of pay received and the presence of financial strain upon him and his family.

Family Adjustment. Many areas were covered in this section, such as adjustment to parents, siblings, spouse, and

[2] Barrabee, Paul; Barrabee, Edna; and Finesinger, Jacob E. Barrabee-Finesinger Social Adjustment Scale, 1952. Accepted for publication in the *American Journal of Psychiatry*, 1954.

[3] Housewives and students were rated according to their performance at home and in school.

children, sexual performance, performance of home responsibilities, and the nature of relationships. The affect in each of these areas was discussed in detail. This section was divided into two parts, one related to marital adjustment and the other to adjustment of single people.

Community Adjustment. Here the patient was asked the number of friends he had, how much socializing and what kind of socializing he did with them. Information was obtained as to whether or not he made use of or participated in the available community activities and organizations. The affect pertaining to these adjustments was also recorded.

The data gathered regarding each of these four major areas of social adjustment is quantified by assigning scores to items in sub-areas within each major area. Weights are assigned to each sub-area in accordance with the criteria of the scale. The score for each major area is derived from those sub-scores. The numerical value of the score in each major area indicates its position on a five-point scale ranging from five, "very satisfactory," to one, "very unsatisfactory." The position of the score in each of the four areas of social adjustment permits presentation of the individual's social adjustment as a profile. For the purpose of illustration we shall assume that a hypothetical patient received the same score of either 1, 2, 3, 4, or 5 respectively in all four areas. His social adjustment would be described as follows:

1. Very unsatisfactory social adjustment: unemployed. Financially completely dependent, assumes no responsibility in the family, no socialization in the community. Affect in all four areas very disturbed or very dissatisfied.

2. Unsatisfactory social adjustment: employed a quarter of the time or sheltered part-time, changes jobs for poorer jobs, considerably dependent financially, shares very little of the home responsibilities, rarely participates in community or social activities. Affect in all four areas disturbed or dissatisfied.

3. Barely adequate social adjustment: employed half-time or sheltered full-time, changes for equal jobs or for poorer jobs. Slightly dependent financially or financially dependent with strain. Shares a fair part of his home responsibilities. Occasionally participates in community or social activities. Affect in all four areas neutral.

4. Satisfactory social adjustment: employed three-fourths of the time, changes for equal jobs, financially independent but not affluent, assumes home responsibilities, often participates in community or social activities. Affect in all four areas pleased or satisfied.

5. Very satisfactory social adjustment: working full-time, changes only for better job, financially independent and affluent, assumes and performs home responsibilities adequately and efficiently, very often participates in community and social activities. Affect in all four areas very pleased or very satisfied.

The method used for contacting ex-patients was suggested by Edna Barrabee, namely, that of sending a registered letter and requesting a return receipt. An addressed postcard was enclosed in the letter asking the ex-patient to check whether or not he would keep the appointment made for him in the letter. If the postcard was not received from the ex-patient within a few days he was called on the telephone and again asked to keep the appointment.

Material

The subjects of this social adjustment follow-up study were ex-patients who were in the community three years following the date of their commitment to the Boston Psychopathic Hospital in 1949. The average length of stay in the hospital during this admission in 1949 was 90 days. The average follow-up period from date of discharge was two years and nine months. They include those patients who had been returned to the community from the Boston Psychoathic Hospital and had been discharged from the hospital following the successful completion of one year's "visit" in the community. They do not include those patients who were transferred from the Boston Psychopathic Hospital to other state hospitals and were subsequently discharged to the community. The subjects in the study number 144. Table 1, column E shows their classification by diagnosis. Column A indicates the *original* group of admissions from which they were drawn, and Column B indicates the subsequent "dischargee" group from which they were drawn. Columns C and D indicate the number of "dischargees" who had relapsed and were in mental hospitals or who were dead at the 3-year point (24 and 4 respectively).

TABLE 1. RESULTS OF 3-YEAR FOLLOW-UP OF PATIENTS COMMITTED TO THE BOSTON PSYCHOPATHIC HOSPITAL IN 1949

	A	*B*	*C*	*D*	*E*
	No. Committed to Hospital	*No. Discharged from Visit*	*No. in Mental Hospital at 3-Year Point* *	*No. Dead at 3-Year Point* *	*No. in Community at 3-Year Point*
Schizophrenia	118	82	16	1	65
Affective psychoses.	79	64	5	1	58
Psychoneurosis	7	5	0	0	5
Organic psychoses..	41	21	3	2	16
Totals	245	172	24	4	144

* Of the number discharged from visit (Column B).

Table 2, Column B indicates the number of ex-patients who responded to our request to make an appointment with us and participated in being interviewed with respect to their interpersonal relations and social adjustment. Interview data were obtained from 65 patients. Table 2, Column C indicates the number of ex-patients who did not keep appointments but who gave information about themselves by mail or telephone or whose relatives or social workers provided information. Non-interview data were obtained from 41 ex-patients. The total number of ex-patients on whom data were obtained was 106 (74 percent of the 144 who were in the community at the three-year follow-up point). The remaining 38 ex-patients were divided equally between those whose address could not be discovered and those who preferred not to be interviewed or

TABLE 2. RESULTS OF ATTEMPTS TO INTERVIEW EX-PATIENTS IN COMMUNITY AT 3-YEAR FOLLOW-UP POINT

	A	*B*	*C*	*D*	*E*
	No. in Community at 3-Year Point	*Information Obtained by Interview*	*Information Obtained Other Than by Interview*	*Patient Did Not Respond*	*Patient Could Not Be Located*
Schizophrenia	65	30	18	9	8
Affective psychoses.	58	29	15	7	7
Psychoneurosis	5	2	2	1	0
Organic psychoses..	16	4	6	2	4
Totals	144	65	41	19	19

to give information about themselves (see Table 2, Columns D and E).

Results

The results of this study are conveyed most clearly by dividing the material in two parts: (A) occupational and economic adjustment, and (B) family and community adjustment.

The significance of the data having to do with occupational and economic adjustment is more readily recognized by separating the patients studied into four categories based on their willingness or unwillingness to be interviewed and on the occurrence or non-occurrence of relapse and re-hospitalization during the three-year period. Table 3 gives account of the occupational and economic adjustment of patients in each of these categories.

Table 3

	Number of Patients	*B–F Occupational Score*	*B–F Economic Score*
(1) Submitted to interview; no relapse.....	45	4.0	2.9
(2) Submitted to interview; had had relapse.	20	3.3	2.6
(3) Did not submit to interview; no relapse..	33	3.6	2.7
(4) Did not submit to interview; had had relapse	8	2.8	2.3
Total	106	3.7	2.7

We call attention to the fact that much more detailed and accurate information was obtained about patients in categories (1) and (2) (patients who were interviewed) than about non-interviewed patients (3) and (4). Information about the latter was obtained indirectly from relatives or social workers and was converted into an estimated Barrabee-Finesinger adjustment score.

Inspection of Table 3 discloses that taken as a whole the patients studied made an average B-F occupational score of 3.7, meaning that they were achieving better than a "barely adequate" and very nearly a "satisfactory" adjustment. Their average economic score, however, was 2.7, which indicates that they were achieving an economic adjustment which was less than "barely adequate." We can say then that the "average" ex-patient was getting along

quite well in his job but was experiencing definite stress in maintaining financial independence.

As might be expected, the highest scores in both occupational and economic adjustment were made by the "non-relapsers." It might be mentioned that the superiority of the "non-relapsers" over the "relapsers" in these areas maintained itself among both the interviewed and the non-interviewed patients.

Comparison of the Barrabee-Finesinger occupational adjustment scores achieved by patients classified by sex and admission status is shown in Table 4. The scores of patients whose 1949 admission was either a first or a re-admission had very little spread, namely, 3.7 and 3.4 respectively. The scores of males and females had a still smaller spread, 3.7 and 3.5 respectively. The only significant difference to be noted is that between re-admitted males and females. Here the scores were 4.0 and 3.0 respectively. The higher score achieved by re-admitted males probably indicates that the latter represent a more stringent selection of first-admission patients discharged to the community than in the case of females. We suggest that socio-economic factors influence both the hospital and the families of patients not to sanction discharge of male patients to the community unless they have made a convincing "comeback." Comparatively speaking, there is greater willingness to return females to the community whose "comeback" has been something less than complete. The finding that first-admission females achieved a better score (3.9) than first-admission males (3.5) would seem to contradict this interpretation. On the other hand, this finding can be invoked to support the contention that the re-admitted females represent a selection of patients who did the poorest in a protecting home environment and that the re-admitted males represent a selection of patients who again broke under the relatively greater stress of an unprotecting work environment.

Comparison of the average Barrabee-Finesinger occupational adjustment scores achieved by patients classified by diagnostic syndrome is shown in Table 5. The scores of affective and psychoneurotic patients (3.9 and 4.2 respectively) were significantly higher than those of the organic and schizophrenic patients (3.0 and 3.2 respectively). The differ-

TABLE 4. BARRABEE–FINESINGER OCCUPATIONAL SCORE BY ADMISSION STATUS AND SEX

	1st Ad. Males		*Re-Ad. Males*		*1st Ad. Females*		*Re-Ad. Females*	
	No. Pts.	Average B.F.O.S.	No. Pts.	Average B.F.O.S.	No. Pts.	Average B.F.O.S.	No. Pts.	Average B.F.O.S
(1) Submitted to interview; no relapse.....	15	3.9	4	4.8	17	3.9	9	3.2
(2) Submitted to interview; had had relapse...	5	3.0	3	5.0	7	3.0	5	2.8
(3) Did not submit to interview; no relapse....	16	3.4	5	4.0	5	4.8	7	3.1
(4) Did not submit to interview; had had relapse	3	3.3	3	2.3	1	5.0	1	1.0
Total	39	3.5	15	4.0	30	3.9	22	3.0

(Grand total = 106)
Average score for all 1st Ad. = 3.7
" " " " Re. Ad. = 3.4
" " " " Males = 3.7
" " " " Females = 3.5

TABLE 5. BARRABEE–FINESINGER OCCUPATIONAL SCORE BY DIAGNOSTIC SYNDROME

	Schizophrenic		*Affective*		*Organic*		*Psychoneurotic*	
	No. Pts.	Average B.F.O.S.	No. Pts.	Average B.F.O.S.	No. Pts.	Average B.F.O.S.	No. Pts.	Average B.F.O.S
(1) Submitted to interview; no relapse.....	19	3.1	22	4.4	2	3.0	2	3.5
(2) Submitted to interview; had had relapse...	11	3.3	7	3.5	2	2.0	0	0.0
(3) Did not submit to interview; no relapse....	16	3.4	10	3.7	6	3.3	1	5.0
(4) Did not submit to interview; had had relapse	2	2.5	5	2.6	0	0.0	1	5.0
Total	48	3.2	44	3.9	10	3.0	4	4.2

(Grand total = 106)

ence between the schizophrenic patients and those with affective disorders is the greatest in category (1) who submitted to interview and had had no relapse during the follow-up period. The score difference is between 3.1 and 4.4. The highest score of the patients with affective disorders may be in part related to the fact that they spend less time in the hospital due to the rapidity with which electric shock interrupts the psychosis. The schizophrenic patients on the other hand spend a longer period in the hospital because their treatment, whether insulin-coma or psychotherapy, is more prolonged. The longer period of hospitalization in the case of schizophrenics is a factor which minimizes their chance of returning to the jobs they had before the onset of their psychosis.

Comparison of the Barrabee-Finesinger economic adjustment scores achieved by patients classified by sex and admission status is shown in Table 6. The difference in average scores here is not as great as in the case of the occupational adjustment. However, they indicate that here again re-admitted males do better than first-admission males, that first-admission females do better than re-admitted females. This suggests that re-admission selects men and women on opposite bases; namely, it selects the most adaptive of males and the least adaptive of females as described under occupational adjustment.

Comparison of the Barrabee-Finesinger economic adjustment scores achieved by patients classified by diagnostic syndrome is shown in Table 7. Here the difference in scores is small or probably not significant. Yet their rank comparison places patients with psychoneurosis and affective disorder above patients with organic and schizophrenic disorders.

Family and Community Adjustment

Family adjustment and community adjustment could not be adequately investigated except for the 65 patients who were interviewed. Data obtained indirectly on the remaining 41 patients of the 106 were insufficient to determine scores on the Barrabee-Finesinger Scale.

Comparison of the family adjustment scores achieved by patients classified by sex and admission status is shown in

TABLE 6. BARRABEE–FINESINGER ECONOMIC SCORE BY ADMISSION STATUS AND SEX

	1st Ad. Males		*Re-Ad. Males*		*1st Ad. Females*		*Re-Ad. Females*	
	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.
(1) Submitted to interview; no relapse.....	15	3.0	4	3.0	17	2.9	9	3.0
(2) Submitted to interview; had had relapse...	5	1.8	3	3.0	7	3.1	5	2.4
(3) Did not submit to interview; no relapse....	16	2.7	5	3.2	5	3.2	7	2.3
(4) Did not submit to interview; had had relapse	3	2.3	3	2.3	1		1	3.0
Total	39	2.6	15	2.9	30	3.1	22	2.6

(Grand total = 106)

Average score of all 1st Ads. = 2.8
" " " " Re. Ads. = 2.7
" " " " Males = 2.7
" " " " Females = 2.9

TABLE 7. BARRABEE–FINESINGER ECONOMIC SCORE BY DIAGNOSTIC SYNDROME

	Schizophrenic		*Affective*		*Organic*		*Psychoneurotic*	
	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.
(1) Submitted to interview; no relapse.....	19	2.6	22	3.0	2	2.0	2	3.0
(2) Submitted to interview; had had relapse...	11	2.5	7	2.7	2	3.0	0	0.0
(3) Did not submit to interview; no relapse....	16	2.6	10	2.8	6	2.7	1	4.0
(4) Did not submit to interview; had had relapse	2	2.0	5	2.6	0	0.0	1	2.0
Total	48	2.5	44	2.8	10	2.6	4	3.0

(Grand total = 106)

TABLE 8. BARRABEE-FINESINGER FAMILY ADJUSTMENT SCORE BY ADMISSION STATUS AND SEX

	1st Ad. Males		*Re-Ad. Males*		*1st Ad. Females*		*Re-Ad. Females*	
	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.
(1) Submitted to interview; no relapse.....	15	3.6	4	3.5	17	3.6	9	3.3
(2) Submitted to interview; had had relapse...	5	2.5	3	3.5	7	2.9	5	2.7
Total	20	3.3	7	3.5	24	3.4	14	3.1

(Grand total = 65)

Table 8. Here again the most significant finding is the better score (3.5) of re-admitted males compared to that of re-admitted females (3.1). This finding supports our contention that re-admission tends to select more adaptive males and less adaptive females.

The community adjustment scores achieved by patients classified by sex and admission status are shown in Table 9. All groups except re-admitted females have scores very close to adequate (which is 3.0). The latter have a score very close to poor (which is 2.0). This low score is consistent with the comparatively poorer scores made by this group of patients in all the adjustment areas.

Comparison of the family adjustment scores achieved by patients classified by diagnostic syndrome is shown in Table 10. The numbers of patients included under organic psychosis and psychoneurosis are too small to warrant comment. The higher score achieved by patients with affective psychosis as compared with schizophrenic patients may be attributed to the fact that affective disorders are more understandable to families and people in general than the schizophrenic disorders. In view of this, it is noteworthy that the family adjustment of the schizophrenic group was adequate (score 3.0).

Community adjustment scores achieved by patients classified by diagnostic syndrome are shown in Table 11. Again the numbers of patients with organic psychosis and psychoneurosis are too small to warrant comment. As was the case with family adjustment, patients with affective disorders achieved a higher score than patients with schizophrenic disorders. It is noteworthy that the affective group did not make a better score than adequate (3.0). The poor community adjustment of the schizophrenic group is more in accordance with clinical expectations.

Comparison of Social Adjustment of "Relapsers" and "Non-Relapsers."

The social adjustment scores of 20 patients who had a relapse during the three-year follow-up period and of 45 patients who had no relapse are shown in Table 12. It is immediately apparent that the "relapsers" have a poorer rating in all four areas of social adjustment than the "non-relapsers."

TABLE 9. BARRABEE-FINESINGER COMMUNITY ADJUSTMENT SCORE BY ADMISSION STATUS AND SEX

	1st Ad. Males		*Re-Ad. Males*		*1st Ad. Females*		*Re-Ad. Females*	
	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.
(1) Submitted to interview; no relapse.....	15	3.2	4	2.9	17	3.0	9	2.4
(2) Submitted to interview; had had relapse...	5	2.0	3	2.8	7	2.4	5	1.7
Total	20	2.9	7	2.8	24	2.8	14	2.2

(Grand total = 65)

TABLE 10. BARRABEE–FINESINGER FAMILY ADJUSTMENT SCORE BY DIAGNOSTIC SYNDROME

	Schizophrenic		*Affective*		*Organic*		*Psychoneurotic*	
	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.
(1) Submitted to interview; no relapse.....	19	3.1	22	3.9	2	3.8	2	3.3
(2) Submitted to interview; had had relapse...	11	2.9	7	3.0	2	2.3	0	0.0
Total	30	3.0	29	3.6	4	3.0	2	3.3

(Grand total = 65)

TABLE 11. BARRABEE–FINESINGER COMMUNITY ADJUSTMENT SCORE BY DIAGNOSTIC SYNDROME

	Schizophrenic		*Affective*		*Organic*		*Psychoneurotic*	
	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.	No. Pts.	Average B.F.E.S.
(1) Submitted to interview; no relapse.....	19	2.6	22	3.3	2	3.4	2	2.2
(2) Submitted to interview; had had relapse...	11	2.2	7	2.2	2	1.9	0	0.0
Total	30	2.4	29	3.0	4	2.9	2	2.2

(Grand total = 65)

TABLE 12. BARRABEE-FINESINGER SOCIAL ADJUSTMENT SCORES OF "NON-RELAPSERS" AND "RELAPSERS"
(based on 65 ex-patients who were interviewed)

Occupational Adjustment		*Family Adjustment*		*Community Adjustment*		*Economic Adjustment*	
Average Score of 45 "Non-Relapsers"	Average Score of 20 "Relapsers"	Average Score of 45 "Non-Relapsers"	Average Score of 20 "Relapsers"	Average Score of 45 "Non-Relapsers"	Average Score of 20 "Relapsers"	Average Score of 45 "Non-Relapsers"	Average Score of 20 "Relapsers"
4.0	3.0	3.5	2.8	2.9	2.2	2.9	2.6

Both groups of patients have their best rating in occupation adjustment and their next best rating in family adjustment. The "non-relapsers" have the rating 2.8 in both community and economic adjustment, a rating which is slightly less than "barely adequate."

The lowest score of the relapsers is in community adjustment. This score, 2.2, is very near "unsatisfactory" and for that reason is of particular significance. It not only identifies the area of social adjustment in which the relapsers had the greatest difficulty, but its absolute numerical value in the Barrabee-Finesinger Scale is one which indicates an unsatisfactory level of adjustment as theoretically conceived by the authors of the scale in terms of deviation from the social norm. As such, this score suggests that clues to the factors underlying need for re-hospitalization of ex-patients of mental hospitals are more likely to be found through study of the community relations of the ex-patient than of his occupational or family relations *per se.*

More thorough investigation of the social adjustment data collected in this research by comparing sub-groups of patients reveals that two sub-groups deviate notably from the pattern described above. The re-admitted males who relapsed did not have social adjustment scores which differed from those of the non-relapsers. The small number of patients involved (seven in all) detracts from the significance of this deviation. Schizophrenic patients who relapsed also had social adjustment scores which did not differ markedly from those of patients who did not relapse. Here again the lowest rating is in community adjustment and very near the "unsatisfactory" level.

Comparison of the social adjustment scores of patients with affective psychoses with those of schizophrenic patients demonstrates that the scores of the relapsers in these two diagnostic categories are much alike in both pattern and absolute level. The non-relapsers in the two categories, however, present a marked contrast. The non-relapsing patients in the affective category have much higher ratings in all the areas of social adjustment, especially in the occupational and family areas. These findings suggest that the factors underlying the problem of relapse with ex-patients who had affective psy-

choses are more clear-cut than with ex-patients who were schizophrenic. In both cases, community adjustment occupies a position of importance as an area of critical difficulty. But with the ex-schizophrenic patients the difference in level of community adjustment between relapsers and non-relapsers is not great. This would seem to suggest that the factors underlying the relapse of ex-schizophrenics may not be reflected in the social adjustment scale to the extent that they are in the case of affective disorders.

Throughout this study community adjustment has emerged as the area of major difficulty for the ex-patient. It is of equal significance that in every sub-group of patients occupational adjustment ranks the highest of all the areas of social adjustment. This suggests that in our society as it is constituted today (at least in the Boston area and for ex-patients of the Boston Psychopathic Hospital) the ex-patient more frequently experiences satisfaction in getting and having a job than he does frustration. It is noteworthy in this connection that 85 (80 percent) of the 106 ex-patients (on whom we had information) were working at the three-year follow-up point.

The evidence that work-relations are more a satisfaction than a stress and that other community relations are more a stress than a satisfaction to ex-patients suggests that mental health programs can profit from giving more attention to the study of problems involved in facilitating the participation of ex-patients in community life.

Summary and General Comment

The over-all results of this study of social adjustment of ex-patients of the Boston Psychopathic Hospital indicate that on the average patients who are in the community at a three-year follow-up point are making an occupational adjustment which approaches the level of "satisfactory" and a family adjustment better than "barely adequate" as determined by the Barrabee-Finesinger Social Adjustment Scale. Their community and economic adjustment, on the other hand, is a little less than "barely adequate." It would appear from these results that the ex-patients studied are "getting along" about as well as might be expected of the average citizen.

The additional finding was made that ex-patients who have

a history of re-hospitalization since their discharge from their 1949 admission also have a poorer level of social adjustment than those who had no relapse. It was found, furthermore, that the relapsers' lowest score was in community adjustment, the only area of social adjustment in which the score approached the low level of "unsatisfactory."

The results also indicate that the ex-patients in this study experience more satisfaction than stress in connection with their occupations.

A point of interest which emerged in the course of this investigation is that "relapsers" are characterized by a history of getting and losing jobs more than the "non-relapsers." This in itself lowers their occupational adjustment score in the Barrabee-Finesinger Scale. As would be expected, these ex-patients also suffer considerable economic strain both from the frequency of job changes and the loss incurred from re-hospitalization. It should be noted here that even though the "relapsers" had frequent job changes, their highest social adjustment score was in the area of occupation.

The superiority of the ex-patient's occupational and family adjustment compared to his community adjustment is to be attributed in part to the extensive amount of social work which is done in behalf of patients committed to the Boston Psychopathic Hospital. More specifically, it is a reflection of the effectiveness of a social work program which begins preparation for the patient's discharge from the day of his admission to the hospital. On the other hand, it is due in part to the hospital's policy of granting patients the freedom to hunt for work prior to their release from the hospital.

It is pertinent also to suggest that the better occupational and family adjustments of ex-patients are the result of social work policy of focusing on the problem of occupation and family relations. Conversely, the poor community adjustment *may* be related to the social worker's relative lack of resources in the area, or to a social work policy which does not include investigation and correction of the patient's community relations.

The relatively poor economic adjustment of the ex-patients in this study as compared with their occupational adjustment is to an important degree due to their dissatisfaction with their ability to pay the debts incurred during hospitalization. The

longer the patient's period of hospitalization, the larger the debt he faced on discharge.

A by-product of this study is the observation that the sequential pattern of "breakdown" in psychosis begins typically in community life with withdrawal from recreational and social activities. This is followed by the appearance of difficulties in the occupational life and a subsequent cessation of going to work. Cessation of work is followed in turn with exacerbation of difficulties in family life, often accompanied by economic problems, which culminate in commitment to the mental hospital. The "build-up" process, concomitant with and continuing after treatment, begins with cementing family relationships, along with week-end visits to the home, and with finding a job, frequently prior to release from the hospital. These are followed in turn by improvement in economic conditions and finally by re-entry into community social and recreational activities. The latter appears to be a most crucial and most difficult step toward complete recovery. The question of whether success or failure in executing this step is to be attributed to the intra-psychic pathology of the individual or to the social context in which he lives is one which can be answered only by further research.

Research which depends on contacting and interviewing ex-patients requires that considerable forethought be given to the manner in which they are to be approached. In this study, many patients and families were responsive and cooperative. Other patients were suspicious and hostile while their families welcomed the chance to discuss with the interviewer their problems involving the ex-patients. And in other cases, both the family and the patient successfully resisted all efforts to obtain an interview with them. Some were annoyed at the method used to establish whether they received our letter or not: namely, that of sending them a registered letter and requesting a return receipt.

The experience of this study suggests that a fuller knowledge of the course of mental illness following treatment depends on obtaining frequent contacts with patients over a period of many years beginning soon after the time of their release from the hospital.

SOME PSYCHOLOGICAL PROBLEMS OF THE INCIPIENT ARTIST

IRVING SARNOFF, PH.D.
Assistant Professor of Psychology, Yale University

IN an exceedingly perceptive series of articles [2, 3, 4] Hutchinson has analyzed the psychological reactions of artists and other creative persons as they grapple with their emergent work. Thus, he describes the period of incubation of ideas, the throes of inarticulation, and the rapture of discovery. The validity of his observations is supported by other investigators [5] as well as the artists themselves.[6]

While findings of this sort have shed much light on the creative process *per se,* they have not touched upon some of the emotional difficulties which may be evoked by a change of role from aspirant to artist. For such a change often arouses fears which are related to unresolved and unconscious conflicts. In this paper, we shall discuss three frequently reported fears which, although they may incapacitate workers in other fields too, seem to have a particularly noxious effect upon the artistic enterprise. We shall refer to these fears as the fear of presumption, the fear of talent, and the fear of inner emptiness.

From the strategic vantage point of a psychotherapist in a university setting,* we were able to follow the inner turmoil of neophyte artists who struggled with these fears during their transition from late adolescence to early adulthood. Occasionally, this transition resulted in the attainment of genuine artistic stature and identity. In others, incipiency threatened to remain a chronic state of being. Finally, the problems of many were resolved by a renunciation of artistic aspirations.

I. The Fear of Presumption

To be an artist, it is necessary to stand as a criterion for oneself and others. Unlike other disciplines, the artistic vocation requires its practitioners to mold reality and experience

* Student Health Service, University of Michigan.

into images of their own creation. This transformation is guaranteed only when the artist can presume freely to interpret things as he sees them, to place the stamp of his perceptions upon the world. In short, the artist does not merely reflect the environment; he also infuses it with meanings which emerge from his uniqueness.

The essence of the artist's task, therefore, demands that he set himself before the unknown and ambiguous world of potential communicants as one whose special endowments permit him to speak rather than listen, to write rather than read, to paint rather than view. In interpersonal terms, the artist assumes a posture of authority with respect to his audience.

For the successful and seasoned artist, this presumption, this role of authority, is no longer an uncomfortable one. Indeed, in many cases, presumption becomes its own reward and grows out of all proportion to any justification for it. Nevertheless, for the incipient artist, the acceptance of this presumptive role may be most difficult.

Unfortunate experiences of childhood and adolescence often convey to the incipient artist the feeling that he is essentially evil or inferior in comparison with others. Once such feelings have been internalized it is impossible for the neophyte to be content with his vocation or creations. For he is split within himself. On the one hand, he feels impelled to create, to express himself through an artistic medium. On the other hand, he feels worthless and guilty whenever he contemplates his artistic relationship to others. In extreme cases, this conflict may result in the production of works which are then either destroyed or kept from public view. Franz Kafka's request that his manuscripts be burned after his death is a striking example of this sort of self-negation.

Paradoxically, inhibitions stemming from the fear of presumption may develop when a person is inwardly or unconsciously so strongly driven by a need to impose his artistic productions on others that he is frightened by the strength and anti-social implications of his drives. Consequently, he tries to protect himself from himself and the world, whose disapproval he expects would follow its discovery of his intense wilfulness, by denying presumption and suppressing the

output of artistic work. Such a person is likely to wear a façade of humble gentility, compliance, and self-effacement.

John R. had precisely this façade. He was a student of design whose work was considered very promising. However, he was never able to bring things to completion, to actualize in detail the ideas and concepts discernible in his initial drawings. Instead, he would sketch out a basic conception and submit it for evaluation as a substitute for the finished product which was patently required. Similarly, in his conversation, he was full of innuendo, trailing sentences, and vague gestures. He would begin a thesis but never get beyond the portents of it.

In psychotherapy it was revealed that his vagueness, his perpetual smile, his soft speech were all part of a deceit; they were, in fact, attempts to make him appear floundering and unassumingly inept. His inner life, however, abounded with fantasies of self-glorification, with almost unimaginable conceit, and with contempt for the ability of his fellow students.

II. The Fear of Talent

To function as an artist it is necessary to commit oneself to one's talent, to acknowledge and develop the creative capacities which one's inner intimations thrust into consciousness. But to support such a commitment the incipient artist must be prepared to accept its consequences: hard work, frustration, responsibility. When he is not so prepared, the existence of his talent threatens him and impels him to turn his back on it. Thus, the very talent which drew him, however tentatively, to artistic endeavor may at the same time arouse his greatest apprehension.

We once treated a girl who reported, among other incapacitating symptoms, an inability to put her thoughts onto paper. Since she desired ultimately to write poetry, her distress may well be understood. Moreover, during our psychotherapeutic sessions, her flow of speech and use of language suggested that her talent was real, if still unleashed.

After several months of treatment, she tried to compose a poem. Much to her surprise, her first line was fluid and beautiful beyond her most wishful imaginings. She jumped up from the desk in what appeared to be a bolt of unrestrained pleasure. Then she proceeded to walk around the room in a

series of excited circles, laughing and talking to herself all the while. Strangely, when the agitation wore off, she found herself to be quite rattled, depressed, and unable to return to her poem.

Upon discussing the incident in our psychotherapeutic interviews, it was apparent that she had been in a frenzy of anxiety rather than in a spasm of joy. Indeed, it was the spontaneous outburst of her own lyricism that filled her with dread. For that single exquisite line meant that she was, or could become, what she had hoped to be. This, in turn, implied that she had to assume responsibility for her talent and its adequate development. Never before had this responsibility been apparent to her. While she had been completely blocked, she luxuriated in her imaginary success without having to work for it. In addition, she indulged herself with extravagant self-pity. It was now clear that all she had ever really wanted to do is to prove that she *could* write poetry. To write steadily, day by day, to suffer the birth pangs of the genuine creative act were not part of the psychological bargains she had made with herself. Hence, when in spite of her inhibitions her creativity emerged, she was overwhelmed by the enormity of its implications

In another case, a young law student consistently refused to exhibit his paintings. He would finish his canvasses, roll them up, and stack them in the recesses of his room. Time after time, his friends, impressed by the quality of his paintings, would suggest ways in which he could offer his paintings for exhibition or sale. But he always countered their suggestions with a host of rationalizations. Some of these seemed very plausible, for example; he was still refining his technique; he was not interested in publicity and money; too much rubbish was already on display: painting for him was merely an emotional catharsis.

Beneath his urbane and disarmingly poised manner, he lived on the edge of desperation. He wanted to acquire a lucrative and prestigeful profession. Yet he was unutterably bored with the law and sustained himself largely on the anticipation of the painting which awaited him when he turned away from his texts. However, he had expensive tastes and enjoyed thinking about the amenities of his future position. Finally,

he liked being considered a bright young man by his teachers and fellow students.

Seen in this light, a successful exhibition of his painting and acclaim of his work by professional critics would push him into the whirlpool of his own conflicting values and needs. So long as he could maintain his compartmentalized life pattern, he would not have to face, in any real way, the possibility of giving up his comfortable but insipid legal role for the more hazardous but satisfying artistic one.

III. Fear of Inner Emptiness

In her book, *On Not Being Able to Paint,* J. Field has described in convincing detail the ways in which fear of self-revelation may prevent the artist from working effectively. The artist, like most people, is loathe to bring to light things which have unpleasant or embarrassing implications.

However, some incipient artists are not only afraid of the skeletons in their closet but also of having no closet at all. They fear that their well of inspiration may be pitifully shallow and quick to run dry, that they do not possess enough inner resources to provide them with ore for the artistic castings that they would hope to mold.

The self is the ultimate resource of the artist. If it is blurred and lacking in substance, he has no foundation for his work. From this standpoint both the university milieu and psychotherapy may be transient enhancement of the incipient artist's lifelong search for selfhood.

An aspiring young writer came to psychotherapy with the complaint of obesity. And, as one might guess, it soon appeared that he had some difficulties in writing which were not unrelated to his presenting symptoms. Thus, in spite of the fact that he had already won a number of collegiate literary awards, he was by no means reassured of his ability. On the contrary, he regarded every success as a matter of chance and was convinced that he would run out of literary talent at any moment.

As the case unfolded, a fairly classical psychodynamic picture crystallized. The boy had always felt severely rejected by his parents and had hit upon eating as a source of solace. Since his parents showed great concern over his gain

in weight, his eating also served as a channel for the expression of hostility against them.

He read as voraciously as he ate, books providing supplementary nourishment. Moreover, he used reading as an escape and as a stimulus for an inordinate amount of fantasy by means of which he transformed the frustrating aspects of his life into a procession of unblemished delights.

Although his writing represented a compensatory device, there was no doubt about his actual talent. However, while he felt quite positively compelled to write, he unconsciously looked upon writing as an act of giving. And giving was repugnant to him because his basic orientation to the world was receptive. He saw himself largely as a hollow shell—frightened, deprived, and shaky. Hence, he recoiled from literary production as an expenditure of substance which he did not have or could ill afford to lose.

In quite a different case, we found the fear of inner emptiness lodged in the same fabric of negative self-perception. This concerned a graduate student of painting who dreaded nothing more than the prospect of attaining a life situation which would permit him to devote himself fully to his art.

Bill, as we shall call him, was the elder of two children and had always been pampered and overprotected by his mother. She assigned to his younger brother the role of a rough and tumble boy, trying constantly to differentiate between the two by emphasizing the "goodness" (passivity) of Bill and the "badness" (activity) of his brother. As a result of his mother's training, Bill acquired the self-image of a pretty, fragile, and immobile china doll. To him, passivity insured safety, approval by his mother, and the maintenance of an identity distinct from his brother; activity, on the other hand, had the most disturbing implications since he felt it might incur his mother's displeasure and jeopardize the superior position which he enjoyed in contrast to his brother.

Early in elementary school, Bill discovered that he had unusual skill at drawing and that in exercising this skill he could gain the admiration of his teachers and schoolmates. These were discoveries of overwhelming importance to him because for the first time in his life he found an active role which would bring him approval rather than rejection. Since

drawing thus became associated with positive social response, he clung to it tenaciously as the sphere of activity upon which he would base his life.

As he progressed through school and into the university, he gave increasing evidence that his choice of an artistic career rested on solid talent as well as emotional needs. His work was very favorably received and all his instructors agreed that he was gifted. In his last year as an undergraduate, he became an accepted member of an informal circle of the outstanding art students at his university. Nevertheless, for all his progress, his works were not numerous, and he felt that he made only minimal use of the time he had available for painting.

In graduate school, and especially as the time approached for him to leave to take a position as an art instructor at a small college, his output diminished markedly. Upset by this symptom, as well as by a host of other personal difficulties, he applied for psychotherapeutic help.

During the course of psychotherapy, we were able to detect the relationship between his rapidly declining productivity and his negative self-image. It appeared that he was reacting with anxiety and withdrawal to the anticipation of a job in which he would have the opportunity to concentrate on his painting. This appalled him because he visualized a situation in which he would be on his own and separated from the circle of colleagues on whom he had depended for a constant flow of ideas, evaluating standards, and stimulation. Hence, he felt unable to find within himself the perceptions, sensitivity, and imagination from which to produce one painting after another.

Discussion and Conclusion

We have just seen how the fears of presumption, talent, and inner emptiness can cause the incipient artist to falter and stumble on the path to his career. These fears never occur in psychological isolation, and their incapacitating effects may be reduced or strengthened by the presence of other emotional liabilities and assets within the context of the individual's total personality. Moreover, two or more of the three fears may be found in the same individual and in varying degrees.

It should be kept in mind that the individual, artist or not,

always works in a social milieu;* and that this milieu, together with the specific nature of his work, tends to define the rewards, risks, and behavior patterns of any vocational role he may choose to play. Of course, some vocational roles are so clearly and rigidly defined that they leave the individual little outlet, even if he desired it, for imagination, spontaneity, and creativity. Indeed, in many kinds of work, the individual may almost be regarded as an extension of the machine insofar as his movements become stereotyped and coördinated with the simple and repetitious movements of the machine. Under these circumstances, it is the machine that requires, the individual who adapts.

At the opposite extreme of role delineation, artists, whether poets, painters, sculptures, or writers, have no such externally supplied behavioral routine on which to rely. Nor, on the other hand, are they so constrained. It is true, of course, that the media with which they work contain intrinsic limitations: stone is not clay and words are not pigment. But it would be difficult indeed to exaggerate the ambiguities which confront the artist.

Having decided to undertake a work of art, no small decision in itself, it becomes necessary for the artist to set about his task, to fill the hours of his day. Should he enforce a tight schedule, or work sporadically in response to the urgency of inspiration? Is it better to concentrate on one project at a time or divide attention among several? And then, if he is an author, what shall he write? Shall he devote himself to fiction, or is drama his real bent? And if it be fiction, what form, what substance?

Even having made these and a myriad of other decisions about his working role, the artist faces an unending stream of ambiguities which must be resolved as he puts paint on canvas or words on paper. For he must be in constant communication with his inner eye and judge when a dab of paint is an adequate expression of what he sees and when it is not; when to add,

* We do not pretend adequately to cover so complex a topic as the artist's role in society. Nor can we hope to deal fully with the special psychological difficulties inherent in the various art media. Instead, we merely wish to call attention to some of the social and psychological problems that confront the artist even if he is not upset by any of the fears we have discussed.

scratch, dilute, sharpen, erase, or cover over; when, at last, to end.

It would be sufficiently trying if he had to contend solely with the uncertainties of his art. But the artist also has to face grave economic insecurity in our society. Lacking the sponsorship of a private or public patron, the artist has to put his work on the market as a commodity. The competition is fierce and exerts a constant pressure on the artist to make his commodity a salable one. Since his own artistic inclinations may run counter to the fashions of the market-place, the artist is often faced with such conflicting alternatives as abject poverty with integrity versus a moderate livelihood with hypocrisy. Many prefer a compromise which involves earning a living by non-artistic labor and doing honest art work in their free time.

Admittedly, the difficulties which confront the artist as a consequence of his task and social role are formidable. When, however, the incipient artist is burdened additionally by the fears which our cases illustrate, his prospects for ultimate success are likely to be very remote. Hence, preventive treatment in such cases may determine the outcome of the struggle. For insofar as he becomes free of those irrational anxieties which stem from the vicissitudes of his emotional development, the incipient artist can direct a greater portion of his energies toward the resolution of the other and multifarious problems he must inevitably encounter.

REFERENCES

1. Field, J. *On Not Being Able to Paint.* London, Heinemann, 1950.

2. Hutchinson, E. D., "Varieties of Insight in Humans," in Mullahy, P. (ed.) *A Study of Interpersonal Relations.* New York, Hermitage Press, 1949.

3. Hutchinson, E. D., "The Period of Frustration in Creative Endeavour," in Mullahy, P. (ed.) *A Study of Interpersonal Relations.* New York, Hermitage Press, 1949.

4. Hutchinson, E. D., "The Nature of Insight," in Mullahy, P. (ed.) *A Study of Interpersonal Relations.* New York, Hermitage Press, 1949.

5. Wertheimer, M. *Productive Thinking.* New York, Harper and Brothers, 1945.

6. Wolfe, T. *The Story of a Novel.* New York, C. Scribner's Sons, 1936.

TWO INTERNATIONAL CRIMINOLOGIC CONGRESSES: A PANORAMA*

SHELDON GLUECK †

TWO international gatherings of importance to the study of crime and the improvement of the administration of criminal justice convened in Europe during the summer of 1955. One was the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Geneva August 22 to September 3; the other was the Third International Congress on Criminology, held in London September 12 to 18. The United Nations Congress is a successor to the quinquennial congresses of the International Penal and Penitentiary Commission beginning in 1872; the criminologic gathering is a periodic feature of the International Society for Criminology, a non-governmental organization.

The United Nations assemblage was made up of official delegations appointed by the various governments, observers from invited specialized agencies, representatives of non-governmental organizations, and several relevant categories of persons "participating in an individual capacity," including members of the bar and judiciary and university professors. The criminologic congress was made up of private participants interested in various aspects of the delinquency and crime problems.

Both meetings were prepared for with much care, and the documentation for both was of an exceptionally high order. If any criticisms on this score are to be made they are, first, that the participants were overwhelmed with an embarrassment of riches in the numerous documents involved, and, second, that much of the material to be discussed did not reach the members in sufficient time to be thoroughly studied before the meetings. One of the most useful documents, which digested and discussed the relevant reports prepared or assembled by the secretariat, was compiled by the Federal Bureau of Prisons for use by the American delegation to the Geneva congress.[1]

* Part I of a two-part paper.

† Roscoe Pound Professor of Law, Harvard Law School.

[1] *Information for U. S. Delegates to the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders* (mimeographed).

The United Nations Congress

Over 50 of the 85 governments invited to participate in the United Nations Congress sent some 300 official delegates, each delegation having one vote. Hundreds of other interested persons attended on invitation. Preparations for the Congress took considerable time and were carried on not only in New York but in consultative groups in South America, Europe, the Middle East, and Asia. Recommendations digesting the conclusions of the regional conferences were deliberated on by the appropriate sections of the Congress, modified to meet the views of the discussants, and transmitted to the plenary sessions for debate and adoption.

Resolutions and recommendations of the Congress do not, of course, have the force of law; but they can have a powerful influence because of the governmental status of the participants as well as the wealth of learning and experience represented at such international technical assemblages. The resolutions should strengthen the hands of leaders in the correctional field in countries which are still far behind the procession of correctional enlightenment.

The United Nations Congress considered the following topics:

(1) Standard minimum rules for the treatment of prisoners.
(2) Selection and training of personnel for penal and correctional institutions.
(3) Open penal and correctional institutions.
(4) Prison labor.
(5) Prevention of juvenile delinquency.

It is obvious that the first four topics form a theoretical and functional whole; the fifth appears to have been brought in as an afterthought. Perhaps the reason for the inclusion of juvenile delinquency in an agenda so heavily loaded with penologic issues involving adults is the tremendous recent interest in children's problems and the belated recognition that the study, treatment, and prevention of child delinquency is the really crucial issue; that while there is considerable room for improvement in the area to which the first four items of the Congress were devoted, the problems there involved have previously received a great deal of discussion in both

national and international gatherings;[2] and that even with marked improvements in the incarceration and correction of adult offenders the total influx of crime will not be greatly affected unless the wholesale supplier of adult criminalism—juvenile delinquency—is effectively coped with at the source.

The final report of the United Nations Congress will not be available in print for several months. In the meantime, mimeographed versions of the resolutions and recommendations adopted by the Congress, as well as an edited compilation of these, have been issued by the United Nations General Assembly.[3] Each set of proposals serves as an annex to a resolution adopted in plenary session at the Congress, which requests the secretary-general to submit the recommendations to the Social Commission of the Economic and Social Council for approval; expresses the hope that they will be approved by the Council; provides that they be transmitted to the various governments with the recommendation that favorable consideration be given to their adoption; and that they be given the widest publicity by the secretary-general.[4]

It would require too much space to detail the numerous conclusions of what was a very busy Congress. The following are among the points of major interest.

I

The first section adopted a series of humane Rules for the treatment of prisoners in institutions.[5] While general stand-

[2] See, for example, Glueck, S., "The International Prison Congress of 1930," MENTAL HYGIENE, Vol. XV, No. 4, Oct., 1931, pp. 775–790, and Glueck, S., "Pre-Sentence Examination of Offenders to Aid in Choosing a Method of Treatment" (report to the International Penal and Penitentiary Congress, 1951), *Journal of of Criminal Law and Criminology*, Vol. 41, No. 6, March-April, 1951, pp. 717–731.

[3] U. N. Doc. A/Conf. 6/L. 17, Dec. 1, 1955. Credit is due the general rapporteur, Professor Thorsten Sellin, for the skill with which he wove together the numerous suggestions for recommendations and resolutions.

[4] The resolutions also express the wish that the governments send information on progress, for publication. There are certain variations among the resolutions, especially the one pertaining to juvenile delinquency which requests the General Assembly to transmit the "Report to the Social Commission of the Economic and Social Council, calling its attention to the necessity of maintaining the priority already given to the question of juvenile delinquency in the program of work of the Social Commission," and recommending that the suggestions be included in the "social defense work program."

[5] *Standard Minimum Rules for the Treatment of Prisoners*, report by the secretariat, United Nations, A/Conf. 6/C. 1/L. 1; Amendments A/Conf. 6/L. 4.

ards and recommendations for improvement of peno-correctional practices have been set forth in the conclusions of past international congresses,[6] the Geneva assembly spelled out the standards in detail, modernizing them and converting the platitudinous into the realistic and practical. Only a sampling of the 94 items involved can here be given. At the outset the framers took into account the "great variety of legal, social, economic, and geographical conditions of the world" as making it "evident that not all the Rules are capable of application in all places and at all times," but that they are intended to "stimulate a constant endeavor to overcome practical difficulties in the way of their application, in the knowledge that they represent, as a whole, the minimum conditions which are accepted as suitable by the United Nations."

A basic principle is that the Rules should be applied impartially; that "there shall be no discrimination on grounds of race, color, sex, language, religion, political, or other opinion, national or social origin, property, birth, or other status." At the same time it is provided that "it is necessary to respect the religious beliefs and moral precepts of the group to which the prisoner belongs."

Among the outstanding features of the Rules is the requirement that no person shall be received in an institution "without a valid commitment order" the details of which are to be entered in a bound registration book covering matters of identity, reasons and authority for the commitment, time of admission and release. There shall be segregation of inmates by sex, age, criminal record, legal reasons for detention, and treatment needs. Accommodations should meet detailed health requirements in respect to sleeping, working, and bathing quarters and general sanitation. Wholesome food "of nutritional value adequate for health and strength" should be furnished. Open-air exercise and physical and recreational training should be provided. The services of at least one

[6] See note 2. The draft of rules considered by the Congress was prepared by the secretariat on the basis of regional conferences on the draft of standard minimum rules adopted in 1951 by the International Penal and Penitentiary Commission, A/Conf. 6/C. 1/L. 1, pp. 4–5, and *Information for Participants*, United Nations General Assembly, A/Conf. 6/Inf. 2, pp. 1–2. The rules "are not meant to be purely optional, but on the contrary to be in the nature of a pledge on the part of prison administrations." *Information for Participants, op. cit.*, p. 2.

medical officer with "some knowledge of psychiatry" should be made available at every institution, and there should be prenatal and postnatal care and treatment in women's institutions. A detailed program is set forth for the work of institutional medical officers.

Provisions for discipline and punishment are carefully enunciated, and "inhuman or degrading punishments and use of instruments of restraint" are completely prohibited. Prisoners are entitled to make requests or complaints to the prison administration or judicial authority, and such petitions are to be promptly dealt with. Communication with family, friends, and religious and legal representatives is permitted.

High standards are required for prison personnel (a topic also separately dealt with in another section of the Congress); and it is provided that "so far as possible, the personnel shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers, and trade instructors."

Excellent correctional philosophy is reflected in a number of guiding principles. The aim of imprisonment being "ultimately, to protect society against crime," it is stated that "this end can only be achieved if the period of imprisonment is used to insure, so far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life. . . . To this end, the institution should utilize all the remedial, educational, moral, spiritual, and other forces and forms of assistance which are appropriate and available, and should seek to apply them according to the individual treatment needs of the prisoners," and "should seek to minimize any differences between prison life and life at liberty which tend to lessen the responsibility of the prisoners or the respect due to their dignity as human beings." The always difficult transition from prison to freedom is recognized in the provision that "before the completion of the sentence, it is desirable that the necessary steps be taken to insure for the prisoner a gradual return to life in society . . . the treatment of prisoners should emphasize not their exclusion from the community, but their continuing part in it. Community agencies should, therefore, be enlisted wher-

ever possible to assist the staff of the institution in the task of social rehabilitation of prisoners."

Advanced practices of classification and of individualization of treatment are recommended. Post-institutional aftercare is set forth in detail.

There are special provisions for the mentally ill prisoners, for those awaiting trial and for open correctional establishments.

Discussion.—All in all, the Rules comprise a chart and compass oriented toward the most advanced thinking in the correctional field. Not a few jurisdictions, both in the United States and abroad, have a considerable distance to travel if they would thoroughly implement their correctional attitudes and systems with provisions of which the foregoing are but samples. Some countries will have to change, fundamentally, their penal philosophy, to minimize the retributive and deterrent aspects and maximate the therapeutic and rehabilitative. The draft Rules are intended to be not optional but "in the nature of a pledge on the part of prison administrations." But there is of course neither inspective nor coercive power on the part of any international agency to check on their adoption and on the nature of their implementation in practice. However, the wise provision for the furnishing of technical assistance in the correctional field to governments requesting it may in the long run prove much more efficacious than coercion would be. Even if many of these Rules are not soon adopted, their publication should have the desirable indirect effect of causing a reexamination of fundamental conceptions and misconceptions in penal law from the realistic point of view of judging regimes by practical results in terms of reform versus recidivism.

II

An important *Leitmotif* of the recommendations of the section dealing with the *selection and training of personnel,*[7] is the statement in a heading that "prison service [is] in the nature of a social service." This is said to be a "new con-

[7] *The Recruitment, Training, and Status of Personnel for Adult Penal and Correctional Institutions,* report by the secretariat, United Nations, A/Conf. 6/C. 1/L. 2; *Amendments* A/Conf. 6/C. 1/L. 2.

ception . . . reflected in the tendency to add to the staff an increasing number of specialists, such as doctors, psychiatrists, psychologists, social workers, teachers, technical instructors," working together as a team. It is recommended that the full-time institutional staff have the status of nonpolitical civil servants with high qualifications, professional training, and attractive salaries and living conditions. Training prior to final appointment, in-service training, discussion groups, and staff conferences are provided for.

Discussion.—It is obvious that when a state shifts its practices from an essentially retributive-repressive program to one emphasizing human dignity and reformability it must place its correctional apparatus in skilled hands and emotionally well-balanced personnel. Surely, the perplexing task of salvaging human personality and character in cases where parents, teachers, and clergy have apparently failed is one that requires the highest talents and the marshaling of the deepest wisdom that the biosocial disciplines can contribute. A familiar source of failure of reform movements in the correctional field is reliance on a new statute or code or prison structure to solve problems which only human dedication and ingenuity can hope to deal with successfully. This is not to say that the "behavioral scientists" can be expected to "cure" crime through magic nostrums. The chief justification for staffing the correctional agencies with professional personnel is that they represent a deliberate effort to be *thoughtful* in coping with human maladjustments, instead of prejudiced or emotionally biased in angry resentment or superficial sentimentality.

In calling attention to the need for professional staffs in the correctional process the standards adopted by the Congress should strengthen the hand of the pioneers in the improvement of correctional practices in countries where it is still believed that repression is the prime remedy for crime and that professional personnel are not needed because it requires no special psychiatric, sociologic, or anthropologic training to use force. But even in certain American states where some effort is made to modernize the peno-correctional regime, the recommendations, if brought to public attention, should raise questions about whether political affiliation should continue

to be a chief qualification for appointments in the correctional field and whether a state can afford the wasteful luxury of untrained and unenlightened prison personnel. For here, as in so many of the affairs of life, it is not so much statutes, systems, or "set-ups" as human beings who make or break the situation; and Pope's famous couplet holds true, particularly in the government of peno-correctional institutions:

> "For forms of government let fools contest;
> What'er is best administer'd is best."

III

The recommendations pertaining to open institutions,[8] that is, those "characterized by the absence of material or physical precautions against escape (such as walls, locks, bars, and armed or other special security guards) and by a system based on self-discipline and the inmate's sense of responsibility toward the group in which he lives," provide that the selection of persons for admission to such semi-free establishments should "be made on the basis of a medico-psychological examination and a social investigation," since "the criterion governing the selection of prisoners for admission to an open institution should be, not the particular penal or correctional category to which the offender belongs, nor the length of his sentence, but his suitability for admission to an open institution and the fact that his social readjustment is more likely to be achieved by such a system than by treatment under other forms of detention." The advantages of the open institution are set forth. It is considered that it "represents one of the most successful applications of the principle of the individualization of penalties with a view to social readjustment," and, since it also has the advantage of counteracting many of the disadvantages of short-term imprisonment, it is recommended that the open system be extended "to the largest possible number of prisoners," subject to the necessary conditions of careful selection of the prisoners and proper management of the institution. Detailed measures are set forth intended to facilitate success under open-institution treatment.

A difficulty frequently encountered in connection with open

[8] *Open Institutions*, report by the secretariat, United Nations, A/Conf. 6/C. 2/L. 1; *Open Institutions*, recommendations adopted by Section II, A/Conf. 6/L. 2.

establishments is presented by the understandably apprehensive attitude of residents nearby. The recommendation includes the necessity of obtaining "the effective cooperation of the public in general and of the surrounding community in particular for the operation of open institutions." Emphasis is placed on the need of limiting the inmate body to a group small enough to permit of the officers' thorough acquaintance with the character and needs of the individual prisoner.

In addition to the series of pamphlet reports prepared by various national contributors to the symposium on open institutions and to the general report by the secretariat, two are of particular value in supporting the conclusions of the section regarding the value of open institutions as a major facility of the apparatus of correction and in assessing the conditions as to personnel and regime which are necessary for successful operation of the open institution.[9]

Discussion.—The considerable interest of the section and Congress on the value of correctional establishments in which both the mental climate and the physical facilities are symbolic of a belief in the possibilities of therapy and rehabilitation of many offenders is a good antidote to the frequent American emphasis upon fortresses of "maximum security." It is becoming recognized that only a relatively small proportion of prisoners require the steel bars and high wall treatment to which the vast majority of prisoners are unnecessarily subjected. The occasional escapes are not too great a price to pay for the favorable opportunities afforded to many by an open institution for which residents are carefully chosen. Only in this way can the bedeviling internal contradiction in imprisonment be resolved: the incarceration of persons who have demonstrated that they are not sufficiently "socialized" in an artificial, restricted, repressive environment which can only further prevent them from becoming socialized. In an open institution the inmate receives constant practice in balancing his selfish motive to decamp against the responsibility he owes the group to which he belongs and the officers who have expressed their confidence by transferring him to

[9] *Open Institutions: Selection of Offenders Suitable for Treatment in Open Institutions,* by Jose A. Mendez, United Nations, A/Conf. 6/C. 2/L. 3; *Open Institutions: The Place of the Open Institution in the Penal System and in the Community,* by Sir Lionel Fox, United Nations, A/Conf. 6/C. 2/L. 2.

a relatively free environment. He has the opportunity of wholesome identification with desirable parent-figures. He gets practice in the art of "live and let live" and in the satisfactions that come with group approval.

Both as a fundamental institution for the majority of those imprisoned, and as a proving ground for those en route to freedom via parole, there are great potentialities in various types of professionally staffed open institutions. In many countries and in most of the United States, however, the generous adoption of the philosophy, techniques, and personnel of the open establishment will involve fundamental changes in the punishment provisions of criminal codes, the minimizing of the retributive and deterrent impulsions in the criminal law and the maximating of the therapeutic and rehabilitative, the increasing of flexibility of sentences both as to time and place, the enhancing of the role of the administrator of the correctional system, and the employment of therapists of various kinds.

IV

The recommendations on the perennial topic of *prison labor* are also essentially in harmony with the most advanced thought in the field.[10] For example, one of the general principles attacks a major evil in existing prison labor systems, in insisting that "the interests of the prisoners and of their vocational training must not be subordinated to the purpose of making a financial profit from an industry in the institution." Some penal institutions are still more concerned with the making of money for the state's treasury than the making of men for the state's welfare. The recommendations hold that "work is not to be conceived as additional punishment but as a means of furthering the rehabilitation of the prisoner, his training for work, the forming of better work habits, and of preventing idleness and disorder."

The state-use system, with compulsory governmental pur-

[10] *Prison Labour,* published by the Department of Economic and Social Affairs, United Nations, ST/SOA/SD/5. (A questionnaire study involving 38 countries.) *Prison Labour: Note on Various Aspects of Prison Labour,* memorandum prepared by the secretariat, A/Conf. 6/C. 2/L. 28. *Prison Labour,* draft resolution submitted by the general rapporteur, A/Conf. 6/L. 9. *Prison Labour,* recommendations adopted by Section II, A/Conf. 6/L. 8.

chase of prison-made goods, is evidently preferred to the private-profit contractual system;[11] however, a compromise provision states that "recourse may be had to private industry when sound reasons exist, provided adequate safeguards are established to insure that there is no exploitation of prison labor and that the interests of private industry and free labor are protected." Vocational training is stressed. Trade training is to be adapted to the demands of the free labor market, and trades should be sufficiently varied to permit of fitting occupational instruction to the different qualifications of inmates. Equitable remuneration for prison labor is recommended. "It is desirable that it should be sufficient to enable prisoners, at least in part, to help their families, to indemnify their victims, to further their own interests within the prescribed limits and to set aside a part as savings to be returned to them on discharge."

Certain fundamental issues were left open, and it was recommended that regional consultative groups study such problems as the integration of prison labor with the national economy, remuneration for prison work, "with particular reference to the principle that prisoners should be paid for their work on the basis of normal wages paid in the free labor market," appropriate labor programs for such special prisoners as the mentally abnormal, the "work-shy," and professional classes; work opportunities for prisoners awaiting trial; aid to ex-prisoners in finding work on release.

A very promising resolution was adopted expressing the hope that as a means of facilitating the implementation of the Rules and Recommendations the United Nations will provide technical assistance "to those governments requesting it,"

[11] The position on this matter is somewhat ambiguous. The recommendations as adopted by Section II (August 31, 1955), dealing with prison labor (A/Conf. 6/L. 8), state that when adequate and suitable employment "cannot be organized by private industries or by other means, the state-use system with compulsory government markets may offer a satisfactory solution." The later (December 1, 1955) compilation by the general rapporteur of *Resolutions and Recommendations Adopted by the Congress* (A/Conf. 6/L. 17) states that "it is preferable that this be done under the state-use system with compulsory government markets." In connection with this problem an interesting debate was held at the plenary session when Edward R. Cass, of the American delegation, offered an amendment to the section's resolution. He urged that the state-use system be given preference. On the vote, 15 countries favored the amendment, 14 opposed it, and there was one abstention.

through sending needed experts, establishing institutions for training personnel, organizing seminars, and publishing guides or handbooks "to facilitate the application of the standard minimum rules and the training of personnel."

Discussion.—It is doubtful whether certain of the countries represented at the Congress are in a position to carry out most of the recommendations. Even in the United States of today, the special interests of labor unions and manufacturers tend to clash with what would be a desirable inmate-centered program. It is difficult to see why prison labor is held to compete seriously with free labor if the industries are sufficiently varied.[12] The amount of prison goods produced is very small compared to the total free labor product of the country, and since most prisoners were already at work at the time they committed their crimes it is hard to justify an attitude that by continuing to work in prison they will seriously compete with free labor.

Gradually, there should evolve in many countries a rational and fair solution of the prison labor problem in which (as in the federal and California systems) representatives of organized labor, industry, agriculture, and the public will pool their points of view, bearing in mind that the vast majority of inmates must at all events be freed some time, that members of organized labor and manufacturers' groups form part of that "society" to which ex-prisoners will return for better or for worse, and that it remains true that "Satan finds some mischief still for idle hands to do." In the meantime, the setting of good standards for the prison labor problem should aid prison administrators in persuading legislators of the need of healing a major sore spot in the correctional field by bringing about constructive use of the inmates' working time.

[12] "Although the issue of competition is not currently an active one in general, the data presented above, when considered in conjunction with information contained elsewhere in the report, indicate that most of the states of Europe, North America, and Oceania have either capitulated to those raising complaints of competition by extensive modification of their prison labor programs, or have achieved an uneasy truce with the complainants, the existence of which is contingent upon continuation of high levels of employment and of economic stability. It would be rash to claim that the problem of the relationships between free labor and industry and prison labor has, in any realistic sense, been solved within the more highly developed countries. The issue may be latent rather than settled." *Prison Labour*, ST/SOA/SD/5, United Nations Department of Economic and Social Affairs, New York, 1955, p. 47.

V

It will be noted even from the partial samples presented above that the recommendations, suggestions, and provisions in respect to the adult offender are commendable, both in reflecting the most seasoned thought and experience in the field of penology and in setting standards which the different governments and correctional agencies within the various countries can measure up to at various stages of progress. It is interesting to note, however, that many of these "advanced ideas" were embodied almost a century ago in the famous "Declaration of Principles" of the American Correctional Association in 1870![13]

The most important aspect of the work of the Congress, however, was one which is truly fundamental—juvenile delinquency and pre-delinquency—on which an important basic report was prepared in advance by the secretariat.[14] Much time of the section involved was used in getting this aspect of the agenda on the right track, there being at the outset considerable fruitless discussion of the definitions of delinquency. But the resolution and recommendations that finally emerged from the work of the section are important.[15]

In its basic resolution, the Congress recognized that much fundamental investigation would have to be done. It was recommended that with the aid of expert non-governmental organizations certain researches be included in the social defense work program of the Social Commission of the Economic and Social Council, among them a detailed study of the methods for prevention of juvenile delinquency, "in two stages": the first to be devoted to the "possibility of organizing a social and health care or guidance system co-operating

[13] Formerly the National Congress on Penitentiary and Reformatory Discipline, organized in 1870. For an analysis of the Declaration of Principles, see Glueck, S., "Significant Transformation in the Administration of Criminal Justice," MENTAL HYGIENE, Vol. XIV, 1930, pp. 280–306; or *Crime and Correction: Selected Papers*, Cambridge, Addison-Wesley Press, 1952, pp. 27–53.

[14] *The Prevention of Juvenile Delinquency*, report by the secretariat, United Nations, ST/SOA/Ser. M/7–8 (Provisional uncorrected edition); *General Principles with Regard to the Prevention of Juvenile Delinquency*, note by the secretariat, United Nations, A/Conf. 6/C. 3/L. 3.

[15] "Prevention of Juvenile Delinquency," recommendations adopted by Section III, A/Conf. 6/L. 11.

closely with the diagnostic services, and assistance to parents, particularly in the task of guidance"; the second, to be an assessment of the "practical value of certain direct and indirect measures for the prevention of juvenile delinquency," by means of regional projects in both developed and underdeveloped lands.

Another recommended study was an evaluation of the methods of "special police services dealing with juveniles."

The United Nations Regional Consultative Groups and Seminars were urged to continue to devote attention to juvenile delinquency. Organizations planning future congresses and seminars were asked so to select topics as to permit of "useful comparison of the experience acquired in the various countries." This theme of comparative study was emphasized by a number of speakers. The writer, for example, pointed out that through systematic cooperation between researchers in different lands it may be possible to develop a new science of comparative criminology involving investigations which employ standard definitions and methods; that thereby those influences found to be uniform in different countries could be detected, with the way open for a solid science of criminology. This idea was embodied in the list of recommendations comprising the annex to part 5F of the resolutions and recommendations of the Congress, which deals with research.

The deliberations on delinquency became fruitful after the barren search for definitions was replaced by a proposal that "the discussion and study of the Congress should include not only those juveniles who have committed an act regarded as a criminal offense by the law of their country, but also those whose social situation or whose character places them in danger of committing such an act, or who are in need of care and protection"; and it was emphasized that "preventive work should cover all three categories." Without such a comprehensive point of view the discussions, like the usual activities of juvenile courts, would have been confined to situations in which delinquency is already a *fait accompli,* when even at an early age it is extremely difficult to curb. Once the more realistic point of view was adopted by the section on delinquency, it became evident that the most promising approach

was to emphasize *pre-delinquency*. To have a manageable method of discussion it was decided to deal with preventive work with pre-delinquents in the community, the family, the school, and the social services and other agencies, despite the obvious overlap in the classification.

After emphasizing the importance of the community[16] and neighborhood and their influence on behavior "through the family, the school, religious and other social institutions," the conclusions and recommendations point out that community action to prevent delinquency is largely a matter of organizing the numerous local resources (through co-ordinating councils or similar devices) to provide a milieu "in which children may develop without abnormalities of character" and in which "those who are in danger of becoming delinquent may be discovered and guided toward conformity to normal standards." The recommendations that follow include the integration of official and unofficial services for youth to meet the basic needs of early childhood, not only through wholesome and constructive activities of the family, school, and other social institutions, but also by means of child guidance clinics, parental counseling services, constructive leisure time outlets, and special schools.

Selection and adaptation of preventive activities from other countries are recommended, taking account of cultural differences. Special attention to "delinquency areas" is urged. While it is pointed out that programs of "general social welfare are not sufficient by themselves," to dispense with specific policies directed toward the prevention of delinquency, general improvement in urban housing conditions is called for, to "be so organized as to provide for full community living."

In introducing the recommendations regarding the family,[17] it is emphasized as axiomatic that the family is fundamentally important in development of personality, attitudes, and be-

[16] For a careful comparison of delinquents and non-delinquents in the community, and an indication of the kind of recommendations that emerged from such a study, see Glueck, S. and E. T., *Unraveling Juvenile Delinquency*, New York, Commonwealth Fund, 1950, chapters XIII, XXII.

[17] For a careful comparison of the home conditions and family life of delinquents and non-delinquents, and an indication of the kind of recommendations that emerged from such a study, see *Unraveling Juvenile Delinquency, op. cit.*, chapters VIII, IX, X, XI, XXII.

havior, and that the impact of industralization and urbanization has brought about considerable "social, family, and personal disorganization. According to current opinion, delinquency appears to be intimately connected with the social and cultural changes that have operated through the family."

Profiting from experience, it is recommended "that in those societies that are recently becoming industrialized and where the family is still a well-integrated and effective unit of control, serious effort should be directed to maintaining its cohesiveness in order to mitigate so far as possible the disorganizing consequences of industrialization." It is of major importance that "preventive efforts be designed to produce closer family ties, thus achieving greater affection, emotional security, and control through the family." Recognizing the family as the cradle of personality and character, the recommendations embrace provision of material needs to underprivileged households, including children's allowances where required "to keep the family intact," to avoid the necessity of mothers working outside the home and to protect children of broken homes.

Counseling aids for parents and children are recommended. Conciliation devices for estranged parents, as well as psychologic aid to parents, should be provided. Children should, as far as possible, be kept in the family and there be given treatment for emotional and social needs, due process of law being observed when it is necessary to remove children compulsorily. Where the family situation is seriously inadequate, use should be made of foster homes. Placement in special institutions for delinquents should not be resorted to unless children have actually violated the law and supervision in their own homes has failed. Similarly, placement in caretaking institutions should occur only when care in the child's own home or in some foster home is impossible.

In discussing the role of education,[18] it is pointed out that, next to the home, the school is in the most intimate contact with the child up to adolescence, and that it plays an important role, not merely in his intellectual growth but also in his emo-

[18] For a careful comparison of the school life of delinquents and non-delinquents, and an indication of the kind of recommendations that emerged from such a study, see *Unraveling Juvenile Delinquency, op. cit.*, chapters XII, XXII.

tional and social development. Among the recommendations for the preventive work of the school is the provision of flexible curricula, to take account of individual differences; the school's playing of a "constructive role in the development of character and attitudes among children, with the object of counteracting unhealthy influences in the community"; provision in the educational program of cooperation between school and family, in order to minimize children's difficulties of adjustment; and the placing of greater emphasis upon vocational guidance and other measures designed to aid adolescents in the transition from school to working life.

In connection with such school activities, it is recommended that the training of teachers should include preparation for understanding the problems of childhood and for discovery of children with emotional or behavioral difficulties, and that teachers should be of the type "with which children can properly identify themselves in the development of their character and goals of living."[19] It is recommended that psychologic and social services attached to the school should be developed to advise both parents and teachers and that guidance clinics and testing and treatment facilities for children be established.

In the part of the recommendations dealing with social services (including health agencies), it is pointed out that "as a consequence of the development of conditions of life in the modern community, the ordinary social institutions, such as the family, school, and religious institutions, have encountered increasing difficulty in the effective performance of their functions. In particular, they have had limited success in maintaining stability, integrity, a sense of independence and responsibility of the individual." It is claimed that the "corollary of such a situation is that more and more juveniles are becoming delinquent and it is also responsible for other forms of emotional and social disorders such as psychoneuroses, psychoses, alcoholism, suicide, family breakdown, unemployment."

For the solution of such problems special social agencies are being increasingly called upon. A "full network of social

[19] "We must properly recognize . . . the role of teachers as parent-substitutes and 'ego-ideals' in the structuring of character." *Unraveling Juvenile Delinquency, op. cit.*, p. 288.

and health services" by both official and unofficial agencies is called for where "necessary and feasible," including welfare agencies, psychiatric clinics, family agencies, children's guidance centers, and the like.

Integration and co-ordination of the various community services is necessary to avoid duplication and discover gaps. The co-ordinating agency can determine which type of aid a maladjusted child needs, and serve both as a clearinghouse for cases referred to it by different agencies in close contact with children that require therapy, guidance, or control, and as a central referral device.

Specialized training is required for psychiatrists, psychologists, social workers, probation officers, special school teachers, and others entrusted with children's problems.

Provision should be made for the evaluation of new forms of social action.

There are recommendations also for the development of placement centers for children, legislation for encouraging vocational training, homes, and hostels for juvenile workers and better control of the working conditions of children.

Recommendations were also made regarding the role of various general agencies in the community which are in a favorable position to discover "children who display social or emotional problems." In this connection reference was made to religious bodies, police organizations, and different agencies concerned with constructive use of leisure. As to these general agencies, it was recommended that their activities be integrated more closely into the services and objectives of the other social institutions concerned with the prevention of delinquency.

On the much-debated issue of the influence of cinema, radio, television, and comic books, it was concluded that "more may be gained by a positive emphasis upon the development of constructive and diversified activities . . . than rigid and negative measures of control and censorship."

The final recommendation has to do with the need to advance research, not only to study "causation, prediction, and prevention," but to evaluate the effectiveness of existing preventive measures. "Comparative, co-ordinated, and interdisciplinary research should be carried out to determine the

relative effects of programs in different countries" and "through co-operation between researchers from different countries . . . to develop a highly promising new field of comparative criminology," in order to determine "uniformities and differences in causal influences, in predictive factors, and in results of preventive and treatment programs" and to develop "a true science of criminology." To these ends "the United Nations is urged to continue its support of significant research in these fields."

Discussion.—In all these provisions regarding juvenile delinquency there is nothing startlingly new and nothing that informed students of the problems of delinquency and predelinquency would not subscribe to. But one cannot help wondering whether the call for more and more social welfare agencies to put fingers in the holes of the societal dike is enough to hold back the cultural waters that are said to bring on the evils not merely of delinquency but of neurosis, psychosis, alcoholism, and the like. One is reminded of the statement in *Unraveling Juvenile Delinquency:*

> "To the extent that general cultural pressures and disharmonies make for antisocial behavior on the part of those who find it difficult, or are unwilling, to conform, we are confronted with a tremendous problem which can be managed only by society and an overall social policy. Basic modifications in the general culture are bound to be slow and are usually unplanned. However, we can take advantage of the fact that parents are to a great extent not only the bearers, but also the selective filters, of the general culture, and thus take steps to mold the under-the-roof culture of the homes of young children around socially desirable goals." [20]

A major difficulty with the type of recommendations for the treatment of children's problems adopted by the United Nations Congress derives from the fact that the array of countries represented included on the one hand relatively simple, economically primitive agricultural lands, and on the other the most highly industrialized and urbanized countries the world has ever seen. One can subscribe to the conviction that unwholesome socio-economic conditions which present to the ordinary family in backward lands a desperate elementary struggle for bread and bed are there very relevant to family disintegration, to parental neglect of children, to delinquency. In more developed countries, with a very high

[20] *Unraveling Juvenile Delinquency, op. cit.*, p. 287.

standard of living, such factors take second place to more subtle and perhaps more serious disturbances of the individual personality and of the family as the matrix of character. In the light of the ease with which colorless, abstract generalizations might have resulted from the wide variety of cultures represented at the Congress it is gratifying that the recommendations which emerged are as specific as they turned out to be. Certainly, they should serve as a warning to those lands now eagerly exploring the glittering El Dorado of an industrialized, mechanized, atom-powered, urbanized way of life, to set up social geiger counters to warn of the necessity of preserving the time-tested values of cohesive family life and affectionate parent-child relationships in the face of the onrushing transformations of the general culture.

A noteworthy omission in the recommendations is the absence of any adequate discussion and suggestions in respect to the early prediction of delinquency. The preparatory document on juvenile delinquency,[21] a statement of general principles drafted by an ad hoc advisory committee of experts called together to advise the secretariat states that "specific preventive measures fall into three categories, of which the first two are:

> (i) Prevention by early detection and treatment of potential delinquents before they present a manifest problem.
> (ii) Prevention at the stage of pre-delinquency, *i.e.*, by diagnosis and treatment of the 'problem personality.'"

It would seem that predictive devices for the early screening of potential delinquents should therefore have been hailed as the most valuable techniques of a preventive program. Yet in the document prepared by the secretariat, which in certain respects is a very competent piece of work, the part devoted to prediction (dealt with in connection with discussing causation) is as disappointing as it is non-persuasive. A typical sample of the kind of argument presented in opposition to the prediction technique is the following:

> "Even if those juveniles who were predicted to be pre-delinquents or potential delinquents do become delinquents after X number of years reckoned from the original prediction, such results do not necessarily

[21] *The Prevention of Juvenile Delinquency*, report by the secretariat, United Nations, ST/SOA/Ser. M/7–8, p. 8; reprinted in *International Review of Criminal Policy*, Nos. 7–8, January–July, 1955.

> imply a validation of the prediction tables. The reason is that during the intervening years factors other than those originally taken into consideration in preparing the tables may have played a more decisive role."[22]

Thus one is asked to ignore specific, clearly defined factors which have been demonstrated to be predictively effective in distinguishing potential delinquents from non-delinquents at a very early age (when timely intervention promises really successful preventive effort) in favor of some mysterious, unidentified factors which *may*, through the long arm of coincidence, account for the results in the case of the delinquents only! It is unfortunate that so patently untenable a discussion of a device which is the most promising approach to effective prophylaxis should receive wide circulation. It can only serve to discourage some workers in foreign countries who might be inclined to accept it at its face value. At one session of the Congress, the writer took occasion to answer the criticisms of predictive methods as screening devices for the early detection of potential delinquents, while Dr. Eleanor T. Glueck reported on the validations of the Glueck Social Prediction Table; and it was evident that considerable interest was aroused in the great promise of such instrumentalities in a realistic program of delinquency prevention. But, the following sentence of item F of part V of the *Resolutions and Recommendations Adopted by the Congress* illustrates the limited formal discussion of prediction: "More important, perhaps, than any of the specific conclusions and recommendations submitted above is the obvious need for the development of more research relating to the definition of the term 'juvenile,' to delinquency causation, prediction, and prevention."[23]

A real opportunity was missed, in discussing the rôle of the school in a crime-prevention program, to encourage the development of what promises to be a crucially important device. Since the school is the first testing ground of the child's ability to cope with the systems of prohibitions laid down by society, it is an excellent vehicle for the early identification of symptoms of maladjustment. As was said elsewhere, "In an enlightened educational system, the school could function as the litmus paper of personality maladaptation, reflecting the acid

[22] *Ibid.*

[23] A/Conf. 6/L. 17, p. 47.

test of the child's success or failure in his first attempts to cope with the problems of life posed by a restrictive, impersonal society and code."[24] A highly promising Social Prediction Table, which was developed in connection with a careful comparative study of delinquents and non-delinquents and published in *Unraveling Juvenile Delinquency* together with two other tables designed to predict delinquency, has already undergone several successful validations on samples of cases other than the ones on which the table was built and is at present being applied, experimentally, by the Youth Service Board of New York City to several schools in underprivileged sections, with a view to testing its efficiency and to determining the value of timely therapeutic intervention in preventing delinquency.[25] The school seems to be the most logical agency for the use of such screening devices as part of a widespread prophylactic program designed to nip delinquency in the bud.

It is evident from the recommendations involving juvenile delinquency that the Congress ranged over a wide field of discussion and that, apart from its inadequate treatment of predelinquency predictive devices, it took ample account of various approaches to the pressing problem of delinquency prevention. It is hoped that the next United Nations Congress will be devoted fully to the problem of child delinquency, since this is the crucial prologue to the tragedy of adult criminalism.

(to be concluded in October)

[24] *Unraveling Juvenile Delinquency, op. cit.*, p. 269.

[25] Thompson, Richard E., "A Validation of the Glueck Social Prediction Scale for Proneness to Delinquency," *Journal of Criminal Law, Criminology and Police Science*, Vol. 43 (Nov.–Dec. 1952), pp. 451–470; Axelrad, S. and Glick, S. J., "Application of the Glueck Social Prediction Table to 100 Jewish Delinquent Boys," *The Jewish Social Service Quarterly*, Vol. XXX (Winter, 1953), pp. 127–136; Whelan, Ralph W., "An Experiment in Predicting Delinquency," *The Journal of Criminal Law, Criminology and Police Science*, Vol. 45 (Nov.–Dec. 1954); "Predicting Juvenile Delinquency," *Research Bulletin Number 124*, April, 1955, published by the Department of Institutions and Agencies, Trenton, New Jersey. Two other validations were presented in papers at the London Congress: one, by Dr. Augusta Bonnard, involving a follow-up of children examined at the clinic of the London County Council; the second, by Mrs. Isa Brandon, a study of adult sex offenders at Sing Sing Prison. Both indicated high predictive power on the part of the Social Prediction Table. These studies will presumably be published in due course. Another validation, not yet published, is Thompson, Richard E., "Further Validation of the Glueck Social Prediction Scale for Identifying Potential Delinquents" (a study of 50 boys from Boston Juvenile Court and 50 girls committed as delinquents to the Massachusetts Youth Service Board).

THE PSYCHIATRIC INTERVIEW AND TEACHER TRAINING*

WARREN WALKER, M.D.,[1] ELEANOR BOTHA, M.D.,[2] AND LEWIS BARBATO, M.D.[2]

BEGINNING with the winter quarter of 1951, at the request of the School of Education the Student Health Service at the University of Denver initiated a program of physical and psychiatric evaluation of students who were candidates for teaching. These evaluations were made at the time the students entered the education sequence in their junior year or, in the case of transfer students, at the time they entered the university. We are reporting on the psychiatric evaluations of 582 students who were seen between January 1951 and June 1953.

The physical evaluation consisted of a complete physical examination, including audiograms and chest photoroentgens. The psychiatric evaluation consisted of an interview by the psychiatrist who had available, at the time of the interview, results of a group-administered modified Thematic Apperception Test. When the study began, the TAT material was interpreted by clinical psychologists and only their findings of significant pathology were furnished to the psychiatrist. Later this procedure was dispensed with and the raw test material written by the student was used by the psychiatrist as a means of supplementing the interview material.

Each student was scheduled by the School of Education for a specified half-hour appointment with one of the university psychiatrists. A preliminary talk was given during the first week of classes of the quarter in which students would be interviewed. One reason for this introduction was the alarm we expected from students at being requested to see a psychiatrist. The introductory talk consisted of a statement of the goals of the psychiatric evaluation and an explanation of the fact that this was a requirement which had no

* Presented before the American College Health Association, April 30, 1955, at Colorado Springs, Colo.

[1] Psychiatrist, Denver; formerly psychiatrist at the University of Denver.

[2] Psychiatrist, University of Denver.

reference to their status in the School of Education but a requirement that must nevertheless be completed. It was also explained that material obtained would be treated with medical confidence and no report other than a statement of completion of the requirement would be returned to the administration. Care was taken to inform students that the responsibility of the psychiatrist was to the student and not, as a screening agent, to the School of Education.

The goals we formulated were stated to the group during the introductory talks as follows:

(1) To provide an opportunity for an educational experience whereby the prospective teacher, using himself as the subject, could learn first-hand something of the structure and functioning of the personality and at the same time acquire certain insights into his own personality with emphasis on his abilities to relate effectively to others.

(2) To help the student discover the presence of any significant emotional problems at a sufficiently early point in his college career so that therapy could be undertaken, when indicated.

(3) To counsel with those students patently unsuited to teaching so that they might choose another vocation in which they could be more effective and happier. We thought it was also valuable that the student have the experience of talking with a psychiatrist.

Each student was seen in a private office and, in general, a form was followed. After identifying information was obtained, each student was asked about his specific professional goals and what it was that had attracted him to teaching. Following this, a brief psychosomatic survey was conducted. We attempted to make it clear that in a statement of general health we wanted the student's opinion and not the fact that he had passed a physical examination recently. A brief evaluation of his current life situation followed, including military experience, with questions about adjustment, hospitalization, and any disciplinary action, the work history and adjustment, the nature of living arrangements, the quality of relationships with significant people, the marital history

and/or sexual adjustment, the general level of social activity, and the degree of financial independence. We then specifically explored the general mood with particular reference to feelings of depression and attempted to determine the amount of anxiety experienced in relation to stress situations. Somewhere in each interview, a direct question was posed as to whether or not the student felt he was in need of help with emotional problems. No particular attempt was made to arrive at a diagnostic formulation unless this happened to be the most convenient method of describing the findings.

One might wonder, in a brief contact of this sort, how information about the structure and functioning of the personality can be transmitted. By focusing the attention of the student on his professional goals and motivations, we tried to convey to him the importance of these areas to emotional health. As the psychosomatic survey proceeded, the possible meaning of symptoms as signals of a disturbed emotional economy was explained. Frequently students voluntarily presented for discussion information about those aspects of their current living situation which they regarded as unhealthy. Many of the students had either part-time or full-time employment in addition to their academic schedule, and it was easy to enter into a brief discussion regarding the proper balance of their "emotional nutrition." By inquiring specifically about dating and whether or not the student felt at ease socially, much information was obtained concerning the patterns of behavior to form the basis for discussion. The difference between "normal" anxiety and neurotic or pathologic anxiety was easily demonstrated in relation to the individual's response under stress situations, such as final examinations, public speaking, and social and professional group activities.

For persons who would soon be intimately concerned with the emotional and intellectual growth of children, we felt that the need for a clear orientation as to the role of the psychiatrist in modern medical practice was unquestionable. We also felt it was of value to desensitize individuals regarding pre-formed fears of psychiatry. Misconceptions regarding this area of medicine were by no means differentially less because this was an above-average intelligence group. Such

misconceptions are often rooted in the defense mechanisms with which each of us maintains his equilibrium. Orientation and desensitization were accomplished experientially rather than didactically.

It has been the common experience of university psychiatrists that problems deserving therapy may be ignored or procrastinated until separation from the college scene becomes imminent. This usually leads to an unsatisfactory brief contact in which the psychiatrist can do little other than recommend to the student that he place himself in a position to undertake treatment in the near future. By focusing the attention of the student on his emotional functioning early in his college career, this project made it possible to identify problems while ample time remained to provide opportunity for adequate therapy.

Comments

As we interviewed these students, we became increasingly interested in the factors that motivated them to choose teaching as a career. By far the largest group appeared well motivated—with a genuine desire to teach, a sincere liking for children, and/or a satisfactory group leadership experience. One could often discern a positive identification with the parental role in the person of their own parents or a well-liked former teacher.

A group less positively motivated toward teaching as a career, regarded it more as a means than as an end. This group included students who preferred marriage but would teach until they could marry; those who felt a "teaching certificate is a good thing to have to fall back on," and those who planned to earn their "bread and butter" by teaching while pursuing a primary objective such as music, art, or the theater.

In some students the primary interest was the subject material and not the teaching of it. A not infrequent comment encountered was "what else can you do with a major in history, sociology, anthropology, etc.?" These individuals, having declared a particular major, arrived at teaching secondarily as a means of using the major productively. Actually, academic advisers had recommended this solution in many

cases. In a corollary group was a large number of the physical education majors whose primary interest appeared to be the specific sport in which they excelled and who subsequently were trying to find a way to put this to use.

A much smaller poorly motivated group appeared to be attracted to teaching in an attempt to satisfy neurotic needs. Many of this group were involved in a mechanism which we have labeled "compensatory identification." This implies a process of dual role-playing in which the individual is identified with the recipient and at the same time is the donor. In this way, he hopes to assume a parental position in order to make up for his own serious emotional deprivation incurred in childhood. The psycho-economy of such an operation, by which we mean the intake and output of emotional energies, is seriously in question. Here an adult role is not attained by giving up infantile wishes but instead the adult role is shammed for the precise purpose of gratifying infantile wishes. Giving is, therefore, seriously jaded by the excessive need to receive. Our experience in treating individuals with this type of motivation suggests that initially such teachers do well; they are eager, energetic, conscientious, and idealistic workers who resent no imposition so long as there is an opportunity to improve the welfare of the student. As time passes, however, one may expect that the rewards become gradually more meager; instead of being able to repay to himself the emotional debt from childhood, the individual finds he has drained his own resources without making a very big dent in the attempt at restitution. In such cases, one often sees disillusionment, bitterness, cynicism, boredom, and quiet resignation to a mechanical type of performance.

There were a few students who had little or no motivation for teaching. These were the occupational drifters who were not sure what they wanted or the overly compliant individuals who had been persuaded to undertake an education major by parents or advisers. It was difficult to increase the awareness of some of these individuals since they seemed quite defensively entrenched in their convictions that teaching would provide an answer to their problems.

Is there any direct correlation between good motivation for teaching and a good teacher? We do not know. In our psy-

chiatric interviews we discovered that the well-motivated students were not always the mature and well-adjusted, for in some we encountered such problems as generalized immaturity, over-dependency, excessive hostility, poor sexual adjustment; frequent depression, tension symptoms, psychosomatic illnesses, and even the classical psychoneuroses. Can these well-motivated but not so well-adjusted individuals make good teachers after graduation? Are some of the motivations which we considered less favorable actually incompatible with successful professional work? We believe that a follow-up study of these students with an evaluation of their performance as teachers could help us find some answers to these questions.

Conclusion

Two problems as to the functioning of the university psychiatrist arose during this project. The first dealt with whether or not a brief evaluation would allow us to bestow upon the graduates not only a diploma but also a psychiatrically tested and approved seal. Such a "seal of approval" to be looked at some two years hence is a fantastic proposition to the modern-day dynamic psychiatrist. We all realize our inability, even when we have a patient under intensive treatment, to predict how he may operate at some time in the future, let alone to foresee the innumerable intervening life situations and experiences which might either compensate or decompensate his emotional function.

The other question which arose was whether or not the university psychiatrist should be utilized by the administration as a screening agent for individuals considered undesirable in the profession. Such a role for the psychiatrist is one which would seriously impair his function as a therapist. In this position, he becomes a depriving agent and exercises undue omnipotence. We are convinced that our present level of knowledge does not permit us to predict accurately whether or not an individual may be a successful teacher. It is vital that the university psychiatrist place himself in the service of the student's welfare and not align himself with other agents who may be attempting to force a decision on the student.

We would like, then, to summarize our impressions of the purposes of the psychiatric interview and the role of the psychiatrist in teacher-training. Being a good teacher, like being a parent, calls for the establishment of a definite framework or emotional climate characterized both by affection and discipline. Without such a framework neither emotional nor intellectual growth can occur to an optimal degree. Lengthy discussions of teaching methods without taking into account the necessity of establishing this basic climate seem to us pointless. We feel therefore that the most important function of the psychiatrist, in this instance, is to increase this awareness; to sensitize the individual to the nature and importance of good emotional function; and to help him identify and modify his own particular problems. Another but less important function because of its relative infrequence is to assist the student to discover a vocation more suited to his basic interests and personality structure, when it becomes apparent that he has chosen a field in which he will be unhappy and unsuccessful.

Aside from our firm belief that the psychiatrist may well participate in a teacher-training program to the benefit of both the individual and the profession, we would like to make one further recommendation. We believe that if a basic course in mental hygiene were made a requirement for prospective teachers and if they were then interviewed by the psychiatrist in the quarter following such a course, greater value could be obtained from the psychiatric interview. Each student would be sensitized for self-examination by virtue of having studied personality growth and development and the minor anxieties aroused by such study could be utilized as a "therapeutic lever" for greater participation. He would also be desensitized toward psychiatry by virtue of his academic contact, and because of his understanding of the universal nature of mental mechanisms could more easily reveal his basic feelings and attitudes without undue alarm.

A MENTAL HEALTH SEMINAR FOR GENERAL HOSPITAL PERSONNEL

A Report

ROMAN J. VERHAALEN, PH.D.,[1] WEIR R. KIRK, M.S.,[2] GEOFFREY M. MARTIN, M.D.,[3] LEILA N. MYERS, M.S.W.,[4] JACK EVANS, JR.[5]

FOR each of the millions of people whose physical illnesses are treated in American hospitals, there exists to some degree a number of mental and emotional stresses directly related to the experiences of being ill and of being a patient.

This paper reports an attempt to increase the awareness of hospital employees and staffs of the importance of these disturbances, and an attempt through use of adult education techniques to diminish the traumatic effects of hospitalization experience by bringing to the whole staff of a hospital an increased knowledge and understanding of their patients' feelings and of the emotional stresses and strains that the majority of the patients undergo.

The Setting.

The decision to conduct a mental health seminar for general hospital personnel originated in the development of the staff and services at the new Riley County Hospital at Manhattan, Kansas.

Manhattan, basically a rural community of nearly 20,000, located at the confluence of the Blue and Kaw Rivers, is considered one of the livelier and more progressive communities in Kansas. Its taxes are slightly above normal, but the

[1] Associate professor of adult education, Office of General Extension (Department of Continuing Education, as of July 1, 1956), Kansas State College, Manhattan, Kansas.

[2] Administrator, Riley County Hospital, and member, Riley County Association for Mental Health, Manhattan, Kansas.

[3] Director, Division of Maternal and Child Health, State Board of Health, Topeka, Kansas.

[4] Director, Division of Mental Hygiene, State Board of Health, Topeka, Kansas.

[5] Consulting psychologist, Division of Mental Hygiene, State Board of Health, Topeka, Kansas.

citizenry receives excellent returns in a pattern of municipal services that are better than average, in good schools, a community-wide recreational program, and even a zoo. Sparked by local groups and by the college located there, a healthy degree of community organization and cooperation exists. One of the newcomers among the community agencies is the Riley County Association for Mental Health, only six years old but vigorous and active.

There is a small commercial area in the northwest, a larger business section in the southeast, and a few industrial plants on the outskirts, but the major part of this small city is composed of residential sections.

The Kansas State College of Agriculture and Applied Science, the second largest educational institution in the state, is located in Manhattan. Sixty-three hundred students were enrolled in the academic year 1954–55. A small Bible College is also in Manhattan.

Fifteen miles away, a century-old military post, Fort Riley, makes its presence felt. The fort is now a combat training center with a population which fluctuates from 10,000 to 30,000.

The city serves a trade area of considerable size, as is true of most "rurban" centers in the Great Plains area. Its nearest neighbor of comparable size is Junction City, 18 miles away. Manhattan supplies medical and hospital services to its surrounding trade area. During the last decade it has outgrown its hospital facilities, so that the new hospital became a necessity.

There is no particular flow of patients to the new county hospital from the others in nearby towns, but the staffs of all the hospitals in the area are reasonably well acquainted with each other and accustomed to getting together from time to time to work out common problems. The other hospitals in the area are generally small, local facilities of 50 or fewer beds.

The combination of the newly-opened hospital, an active local Mental Health Association, and a loose network of hospital cooperation formed the background for the attempt in mental health education.

Development of the Seminar Plan.

The administrator of the new hospital was faced with the problem of integrating a brand new group of hospital workers recruited from the residents of the community, wives of students at the college, and the dependents of military personnel —a staff characterized by high turnover and widely diversified experience. One common factor was this staff's generally inadequate mental hygiene orientation. It appeared to the administrator that two birds might be killed with one stone, and he requested help from the county Mental Health Association.

The board of the Riley County Association for Mental Health thought the request was pertinent and appointed a committee to consider the matter and report back. The committee consisted of the hospital administrator, a school health nurse, and the college's coordinator of nursing education. The committee's report stated:

(1) All hospital patients have feelings connected with their illness and hospitalization.

(2) Their feelings vary according to their personalities and the reasons for hospitalization.

(3) These feelings affect their response to medical care.

(4) The hospital experience has a high potential for being traumatic.

(5) All hospital workers in contact with the patient affect his emotional environment and his interpretation of the hospital experience.

These views, coupled with the fact that there had previously been little concern with the mental hygiene aspects of hospital care, made the committee feel that there would be much value in an educational program in mental hygiene designed to reach all hospital personnel, both professional and non-professional.

These findings were reported back to the board of the Mental Health Association, and were approved. The association thereafter gave strong moral support, and financial assistance within its means.

The committee next invited the Office of General Extension of Kansas State College to join in the project.

Since this department exists to make the resources of the

college available to groups outside the academic walls, it considered the project to be well within its functions—and one which was not pre-packaged, needing only mechanical supervision, but a project which would make good use of the college's skills in planning and executing a program of adult education. The department accepted promptly, agreeing to accept major responsibility for the venture under the general supervision of what might be called a planning committee.

This committee consisted of the original Mental Health Association committee and members of the college's general extension department plus a considerable number of individuals invited in from time to time for advice on particular problems. This last group included members of the staff of the mental hygiene division of the State Board of Health, a school health nurse, members of interested college departments, a physican, and the chairman of the local nurses' association.

The state health department was invited to provide program material, and promptly accepted. Since various divisions of the department are extensively concerned with hospitals, hospital services, mental hygiene, and community organization for preventive mental health services, the plan appeared an effective and economical use of its personnel in the development of a local health program.

Early committee discussions resulted in general plans that were followed quite closely thereafter. A general topic—"Mental States of the Physically Ill"—was agreed upon. It was decided to divide this large topic into a number of smaller ones, according to the kinds of general medical services—hospital administration, obstetrical, surgical, medical services, etc. Thus came into being a general outline of a seven-session seminar series, to be financed partly by the local Mental Health Association and partly by a modest fee.

Several meeting plans were proposed, including the holding of separate meetings for professional and non-professional personnel. It was eventually decided to have all personnel attend the same sessions. Because whole-day sessions of afternoon and evening sessions would make it impossible for on-duty personnel to attend, it was decided to hold one evening session each week.

Technical and mechanical details became the responsibility of the college's Office of General Extension, and they were numerous. The seminar format and the technical level of the presentations had to be considered in view of the heterogeneity of the group. It was eventually decided to have an initial speaker for each session, to introduce the evening's topic with a lecture or film, and to devote the second half of each meeting to small-group discussions and problem-solving, with not more than eight participants seated around small tables.

Interviews were held with the administrators of the hospitals in the area, to determine as nearly as possible what subjects would have the greatest interest and value for the participants. After several discussions, the following topics were arrived at:

(1) The role of administration.
(2) The obstetrical patient.
(3) The pediatric patient.
(4) The medical patient.
(5) The surgical patient.
(6) The chronically ill and aged patient.
(7) The "good" patient: a summary and review.

The planning committee undertook to find well-qualified people to present these topics.

Invitations were extended to hospital personnel in a seven-county area: administrators, physicians, nurses, aides, student nurses, dietitians, housekeepers, kitchen employees, maintenance, and auxiliary workers were included. Hospital administrators were given the responsibility for recruiting their own personnel, which they did ably. Publicity was by personal contact, mail, radio, and press releases.

Final plans called for meetings to be held on seven consecutive weeks, between 7 and 9:30 p. m., on the Kansas State College campus. The college was chosen instead of Manhattan's county hospital, for at least two reasons. As a general rule, educational programs benefit by the aura of learning which surrounds educational institutions.

The Meetings.

The seven presentations and discussions are briefly summarized in the following paragraphs. The techniques of presentation varied, as previously mentioned. There were

lectures, panel discussions, and films. The manner of presentation varied with the individual speakers.

Summary of the Seminar Sessions

Section 1—Administration

Recognizing that any innovation in the patient-hospital personnel relationship depends upon administrative tolerance, the first session was planned to present the administrator's point of view and overall responsibility for the patients' well-being.

The administrator works under two major pressures: (1) the responsibility of providing the best in hospital and medical care, and (2) the responsibility of operating the hospital plant in the most economical and efficient way possible. To do this, he must employ supervisory personnel who can maintain hospital services with a minimum of friction among staff members. His supervisory staff is charged with employment and direction of capable and efficient staff members in the operation of hospital services.

The medical staff determines the care and treatment needed for each patient. Since the most economical treatments may not be the most effective for the patient, the administrator frequently is confronted with complex problems. His job is to create a balance between what is best for the patient and what it is possible to do within the limits of his budget and the capabilities of his staff, and at the same time to ease as much staff frustration as possible.

In a small community, the hospital administrator needs to be aware that "everybody knows everybody else," and must make special efforts to protect the privacy of his patients.

Session 2—Obstetrics

The emotional problems during pregnancy are many and varied. Hospital staff members need to understand and accept the negative as well as the positive feelings of the woman who comes to the hospital for delivery. They need to recognize that the patient has probably experienced the gamut of emotions from happy anticipation to fear of physical pain. They need to know some of the methods of recognizing unexpressed feelings and how to deal with them. They need to know the

extreme importance of the mother-child relationship from the first contact with the hospital until the patient leaves the hospital.

To stimulate thought and discussion of these factors, a film titled "A Concept of Neonatal Care" was shown to demonstrate a plan of rooming-in.

Subsequent discussion brought out a variety of opinions and emotions on the part of members of the group who were mothers themselves. Members of the medical staff present were divided in opinion, and divergent viewpoints made for a lively discussion period. Many seemingly minor points were emphasized to show the need to be aware of the little thoughtful services that make for the patient's mental comfort as well as for her physical care. At the same time, an understanding of the patient's feelings makes easier the task of the staff in accepting what otherwise might seem unreasonable behavior.

Session 3—Hospital Care of the Young Child

The importance of the mother-child relationship was stressed and demonstrated. The hospital staff must be aware of the emotional needs and fears of the young child who comes for treatment. They must understand the basic fear of separation which besets the child and realize the importance of maintaining the mother-child relationship. They must be prepared not only to tolerate but also encourage the "intrusion" of the mother into the hospital routine whenever possible.

Supervisory staff can do much to handle the reactions of nurses-aides and other staff to child-patients by giving them some understanding of the primary emotional as well as physical needs of the child.

Whenever possible it is best for the young child to have a fixed focus of care in relation to a single person when he must be separated from his mother. Normal babies on occasion can go into depression-like shock and suffer severe emotional trauma as a result of the multiple problems of illness and forced separation.

Discussion following the showing of the film, "The Two-Year-Old Goes to the Hospital," brought out a recognition of the various emotions resulting from hospitalization: anger, fear, withdrawal, insecurity, need for protection, etc. At the

same time, group members recognized that the child may consider hospitalization as a form of punishment. Hostile aggressive behavior may be the expression of a lonely, angry, and frightened child. Understanding these emotions and reactions breeds patience and tolerance on the part of hospital staff.

Session 4—General Medicine

Discussion of the emotional problems of the patient hospitalized for medical care was focused on the feelings of a patient, the head of a family, referred for treatment of a heart condition.

The presentation covered the medical aspect of such a case, the feelings of the patient, the fears of the various family members, and the reality factors of family reorganization as a result of prolonged disruption. Many questions come to the patient's mind; fears become to him reality. It is helpful to let him express these feelings to staff members who understand why they arise. The doctor can determine and personalize factual information. Appropriate staff members can deal with the anxiety of family members who are threatened with the loss of support as well as with the loss of a loved family member.

In the discussion, suggestions for helping the patient deal with his anxiety ranged from a statement of the importance of the attitude of the receptionist who must obtain background information, to the need for a general air of confidence and optimism on the part of the hospital staff, to the place of the chaplain and religion in the hospital.

Differences in dealing with the chronic case as opposed to the acute case brought out the feelings of staff members in working with varying degrees of illness. It was emphasized that the attitude of hospital personnel is basically important in the recovery or decline of a patient.

Session 5—Surgery

The importance of body image and personality figured largely in the presentation and discussion of the feelings of the patient referred for surgery. Surgery is often viewed by the patient as mutilation of his body and potentially damaging to his self-respect.

Some of his fears arising in part from misinformation are fear of infection, fear of deformity, fear of pain, likening anesthesia to death. The surgeon becomes the "father figure" to the patient who has a strong need to be dependent. The surgeon can reassure the patient by giving him enough information to relieve his anxiety and by emphasizing the competence of the staff.

The patient can be relieved of his sense of loss—not so much by words as by the attitude and manner in which they are imparted. Yet too much information—like too little—can add to the patient's anxiety.

Members of the hospital staff must be constantly aware that their personal security or anxieties are surely reflected in the patient's attitude toward himself and his situation.

Session 6—The Psychology of the Chronically Ill

The increase in the population of persons over 65 years of age increases the problems of chronic illness. As the individual grows older, he has less energy and strength. He is probably retired and may feel useless and not needed. He may be partially disabled. He may be the victim of a degenerative disease. Many of his generation view the hospital as a place to die.

As a result, he may retreat into childishness and helplessness. He may retreat into apathy and indifference and "give up." In dealing with these feelings the nurse and other staff members must be ready to stand by him and help make him comfortable by allowing him to express his feelings—even those that are hostile and unreasonable—with a calm acceptance of his right to be heard as an individual. Listening to oft-repeated stories and demands will produce feelings of impatience and rejection in the busy nurse unless she can appreciate that a friendly exchange with the patient can reduce the number of times he will call her for minor care.

Simple practical means of utilizing any remaining strength a patient has can often reduce his anxiety over his fears of complete helplessness. For example, a patient who has suffered a cerebral accident may be able to move only one hand. It gives him a measure of mental relief to "exercise" his fingers

on a soft ball. He can be given the feeling that he is actually doing something to assist in his recovery.

Giving emotional support to a patient during his terminal illness requires emotional stability on the part of staff members. To remain calm and sympathetic rather than cold and indifferent to the end of what to the staff is inevitable and commonplace means an added strain on the staff members in attendance.

Session 7—Summary and Review

The summary and review began with a discussion of several questions: (1) What is the nature of illness? (2) What does it mean to be sick? (3) What does it mean to be in a hospital? (4) What produces a feeling of dis-ease? (Disease means dis-ease.)

Illness is the result of both inner and outer stresses. The equilibrium of mind and body processes is upset when a person cannot meet a condition or situation which causes stress. A person may become sick because of a physical, social, or psychological stress. He is most vulnerable when he is emotionally upset. Being sick is a way of adapting to stress. It is a way of solving problems. (It is the job of the physician and hospital staff to find some solution to the stresses which cause the dis-ease.)

In our society a man is required to be independent while a woman may acceptably be dependent. And so when a man gets sick, he is liable to become very sick because then he can be dependent. The same cultural bias may account for much of the chronic illness among women. Illness can be a way out of trouble and for this reason may be retained longer than necessary. In lower income groups, illness is a financial burden, so such patients tend to recover more rapidly.

One of the major problems in recovery is how to teach the patient not to be a patient when he is ready to recover. When he comes into the hospital, he is taught new routines. He gives up his independence. He must adjust to several important personalities: the doctor, the nurse, the aide—each with his own point of view and personality. He has taken on a sort of separate social role. He has learned to be a *patient,* giving up his normal role in his family, and separating from

it. We must all remember that separation such as this is the most devastating of all human anxieties. It may become so great that the patient becomes even sicker. It is the responsibility of the hospital staff to ameliorate this anxiety and start the patient back on the road to health.

Evaluation.

Considerable emphasis is being placed these days on the evaluation of mental hygiene projects, so that mental health may be pursued in an economical and effective manner. This project was evaluated in several different ways: (1) by a questionnaire which was answered by a significant percentage of the participants, (2) by critical letters submitted by various hospital administrators at the conclusion of the course, and (3) by the more or less experienced group leaders who directed it. While all three of these methods do not add up to a strictly scientific or an entirely satisfactory appraisal of what was actually accomplished, they do give a basis for estimating that accomplishment.

The questionnaire consisted of seven simply phrased questions which the participants answered in their own words. The questions dealt with these things: What session was most useful, and why? What session was least useful, and why? Was the participant interested in enrolling in a second, similar, seminar series? What suggestions could the participant offer for improving the program? And, if a second seminar series was offered, who should be invited to attend, and how should it be scheduled?

The results of the questionnaire are presented in Table 1. Insofar as the small number (48) of completed questionaires permits the drawing of valid conclusions, the answers suggest (1) that hospital personnel are particularly interested in the emotional implications of hospital care for children and surgical patients, (2) that the participants were satisfied with the general tenor of the course and would welcome another, and (3) that the constitution of the group, and the scheduling of the program, appeared to the participants to be just about right. The relatively unfavorable response to the sixth session, on the chronically ill, was influenced by a number of variables to the point that it defied interpretation—although it

TABLE 1. A PERCENTAGE TABULATION OF RESPONSES TO EVALUATIVE QUERIES RE A SEMINAR IN MENTAL HEALTH EDUCATION

	Sessions on						
Item	*Administration*	*Obstetrics*	*Pediatrics*	*Medicine*	*Surgery*	*Aged*	*Review*
Attendance	80.5%	84.7%	76.3%	97.2%	47.2%	54.1%	63.8%
Most useful session.	15.7	19.3	20.2	15.7	10.5	4.4	14.2
Least useful session.	23.0	19.7	1.6	24.6	1.6	21.3	8.2

	COMPARATIVE EVALUATION					
	Midpoint			*End*		
	Yes	*No*	*In Doubt*	*Yes*	*No*	*In Doubt*
Participant wishes to re-enroll.....	87.5%	10.4%	2.1%	96.0%	4.0%	0.0%
Participant wishes larger geographical representation	80.4	14.8	4.8	76.0	20.0	4.0
Participant wishes full-time 1 or 2 day session.....	23.9	73.9	2.2	53.8	46.2	0.0

NOTE: Attendance percentages are based on a total paid and unpaid registration of 72. If added across, all others total 100.

raises the possibility that hospital workers are refractory to thinking very deeply about the emotional problems of old age and chronic illness.

The letters from the hospital administrators were variously enthusiastic and critical. One, a physician, thought that the factual data was exactly what his staff needed and that the group discussions had given them a valuable opportunity to formulate and express opinions. He requested a continuation of the project during the coming year and said he would recommend it strongly to others. Another believed that she could notice a changed attitude on the part of her workers to patients in general. "At intervals now," she said, "I can see someone change the wording of a remark or eliminate it entirely . . . all were made to feel the importance of the patient." Most criticisms were directed at particular presentations rather than at the overall effect of the series. There was a strong minority feeling that there should have been somewhat more emphasis on practical techniques to aid the employee in his or her direct care of the patient.

The more or less experienced group leaders in charge of the project felt that it had scored a considerable success and that if repeated it could be improved in several quite definite ways.

In view of the number and diversity of the faculty and the extreme heterogeneity of the participants, it seems particularly necessary in the future to provide for one qualified person who would attend and actively participate in all of the sessions, to provide continuity from week to week. It was felt that this person could function well as the permanent chairman of the discussion portion of the program and that he would be the logical person to present the final review and summary.

The group leaders also thought that the discussion sessions could have made more of a contribution than they did. The weaknesses noted were particularly related to the background and experience of the evening's speaker, who undertook to guide the small groups that were set up after the initial presentation of the subject. When the speaker was used to this sort of procedure and comfortable with it, the discussions were usually stimulating and effective; when he was not, they were much less effective. Another weakness was the lack of time;

usually no more than an hour could be allocated for establishment of the small groups, outline of topics, discussion, and summaries. It might have been a better pattern to set aside whole evenings for discussion, giving the small groups time to work through their own thinking on the subjects and thereby come to a more adequate understanding. There was general agreement that the large, bare college classrooms that were used lacked an intimacy and informality that the course really required.

A final note on effectiveness was furnished by information that filtered back to the program committee by one means or another. A nurse's aide was pleased to find that relationships with her patients improved when she could remember their names and so greet them. A receptionist could see that the families of patients were less anxious, and therefore less contrary, when the front desk treated them with more consideration and understanding. Plans for the remodeling of a hospital were made to provide for rooming-in of mothers and babies. Without doubt, results of this sort will continue to pile up as the months go by, to constitute in the end the most effective evaluation that can be made of the program.

While mental hygiene remains an inexact science, replete with observations and conclusions that cannot be strictly repeated or verified, it is only possible to say that the project here described appears to have met successfully two of its three objectives: to make hospital workers aware of the importance of patients' feelings and of their own importance in modifying those feelings in a favorable way. The third objective, creating an awareness of the most effective methods to favorably influence patients' feelings, seemed to have been met only partially.

ESTIMATING SOCIAL INCOMPETENCE IN ADULTS

KATHARINE M. BANHAM

Duke University

THE federal law providing for grants-in-aid to the permanently and totally disabled between 18 and 65 years of age which came into effect in 1950 presented certain problems of selection for State and County Departments of Public Welfare Disability could be roughly classified into three kinds: bodily or physical handicap, mental disorder, and mental defect. Degrees of physical handicap resulting from deformity, defect, accident, or disease have already been classified by members of the medical and legal professions for purposes of insurance and compensation. Degrees of mental disorder have similarly been classified by psychiatrists for purposes of institutional care and treatment. But the question as to how much mental defect may be considered as permanently and totally disabling has not been definitely answered and presents problems that vary with local conditions.

The results of psychological tests of general mental ability, intelligence tests, have aided in the selection of children and adults for placement in institutions for the feebleminded. Three categories of mental defect were suggested by Lewis Terman on the basis of mental age or I.Q. obtained on the Stanford-Binet Scales of Intelligence. An additional category of borderline deficiency was suggested for adults having a mental age of about 12 years and an I.Q. near 70.

Classifications of mentally deficient and borderline levels of mental ability have been made by authors of other tests. These vary slightly according to the manner in which the I.Q. is determined from the test scores and the representativeness of the sample of population on which the tests were standardized. Tables 1 and 2 show classifications made by Terman, Kuhlmann, and Wechsler from results on their respective tests. The categories were determined statistically and comprised the lowest two or three percent of the population on tested intelligence.

TABLE 1. LEVELS OF MENTAL DEFICIENCY OF ADULTS ON THE STANFORD-BINET INTELLIGENCE SCALE

M.A.	*I.Q.*	*Classification*
0– 3 years	0–25	Idiot level
3– 7 years	25–50	Imbecile level
7–11 years	50–70	Moron level
7– 8 years	50–55	Low moron level
8–10 years	55–65	Middle moron level
10–11 years	65–70	High moron level
11–12 years	70–75	Borderline level

It might be considered a simple matter to select a cut-off line of I.Q. level, below which individuals would be considered permanently and totally disabled on the ground of mental deficiency. There could, for instance, be no doubt as to the total and permanent handicap of idiots and imbeciles. But the moron at the upper level of feeblemindedness may or may not be totally disabled according to the demands of the environment, his physical constitution, emotional stability, and lifelong training.

This problem came to the attention of the writer in her capacity as senior psychologist in the North Carolina State Department of Public Welfare in 1950–51. Intelligence tests were found to be inadequate for determining the degree of mental and social handicap of the middle- and high-grade feebleminded individuals. Some morons living in rural communities were able to earn their own living and to raise and maintain a family. Others of the same intellectual level were practically incapable of supporting themselves and were dependent on others for the necessities of life.

It was thought that possibly the Vineland Social Maturity Scale might help to differentiate the competent from the incompetent feebleminded adults. But since this scale was devised originally for use with children, many of the items,

TABLE 2. LEVELS OF MENTAL DEFICIENCY OF ADULTS ON THE KUHLMANN AND THE WECHSLER-BELLEVUE INTELLIGENCE SCALES

Kuhlmann-Binet Scale		*Wechsler-Bellevue Scale*	
I.Q.	Classification	I.Q.	Classification
below 75	Mentally defective	below 65	Mentally defective
75–84	Borderline	66–79	Borderline

especially at the level of greatest incompetence, were not appropriate for adults. In the absence, then, of a suitable rating scale of social competence for adults of limited mental ability, the writer devised a checklist or inventory of behavior for this purpose. This inventory is described in the following paragraphs and appended in full at the end of this article. Comparison between intelligence test scores and social competence scores are given for a small sample of cases, and suggestions are made as to how the inventory can be of use in social casework.

The Social Competence Inventory for Adults is essentially a standardized interview. Its validity for any individual will depend upon the truthfulness of the informer and the representativeness of the behavior reported. A skilled interviewer would be able to judge fairly well whether the information given by the relative, friend, employer, or guardian of the person to be rated is reliable and valid or not. This would depend, for example, upon how long and how well the informant had known the individual and under what circumstances. Also, it would depend upon the degree of intelligence of the informant himself.

The inventory was intended strictly for the use of professional people trained in the art of interviewing and familiar with the technique of rating, such as psychologists, social workers, and medical practitioners. The usefulness of any rating scale or checklist for assessing behavior is determined to a large extent by the judgment and ability of the rater. Without such ability, scores on a rating scale are meaningless and may be seriously misleading for the person being rated.

The items on the Social Competence Inventory consist of descriptive statements of behavior or habits of action which may be characteristic of a particular adult. Only those items have been included which are essential to some aspect of social competence and self-maintenance. Many of them were selected from case records of persons who had proved incapable of taking care of themselves. The items are arranged in four groups to help classify the nature of the individual's disability, whether that of bodily control, sensory or memory defect, care of self, or emotional control. In each of the four sections

the items are arranged roughly so that the least competent behavior is mentioned at the top of the list and the most competent at the bottom of the list.

The scoring system used is a simple point scale system. Thus, if the scale is to be an accurate measure, some information should be obtained and a score of one or nothing given for every item. It was realized at the outset that this would be an unrealistic ideal. Raters are urged, therefore, to score as many items as possible on the basis of positive information but to place a question mark against those about which they have no information or they are in doubt.

A rating scale of this kind could never be considered an exact measuring device. It is merely a means of general classification. Thus, if two or three items are omitted through lack of information, the broad classification of the person would not be affected. A margin or maximum of five questionable items (marked ?) has been arbitrarily chosen as permissible. No reliance should be placed upon total scores if there are more than five queried items. But the scores on particular items or sections of the inventory may have useful qualitative significance for the caseworker or psychologist, whether the total scores are valid or not.

The broad classification of total scores in degrees of social competence was arbitrarily chosen on the basis of case histories of more than twenty adults who had a long record of incompetence in employment and in self and home maintenance and whose intelligence level was known. This scoring system was regarded as only temporary, but continued use of the scale in the North Carolina State Department of Public Welfare over a period of four years has shown the categories to be valid and useful. The form used in 1951 and 1952 contained 70 items. Several of these were eliminated and others changed in making the final form of 55 items used from 1952 to 1955.

A comparison is given in Table 3 of Social Competence Inventory Scores (final form) and I.Q. on the Stanford-Binet Intelligence Scale, Form L, for persons who were not able to care adequately for themselves and were applying for a grant-in-aid for the permanently and totally disabled between 1952 and 1955. Those persons whose social competence scores

TABLE 3. COMPARISON OF STANFORD-BINET I.Q. AND SOCIAL COMPETENCE SCORES FOR APPLICANTS FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED *

	White Female	*Negro Female*	*White Male*	*Negro Male*
Number of cases	27	9	21	12
Average age	43	40	42	36
Standard deviation	12.1	15.1	13.9	9.2
Average I.Q. (S-B, Form L)	40	34	39	32
Standard deviation	10.2	9.4	11.6	7.0
Average Social Competence score	26	26	22	22
Standard deviation	8.2	9.4	8.5	10.9
Coefficient of correlation (rank difference)	.52	.55	.43	.40

* These figures are quoted with the kind permission of Commissioner Ellen Winston, North Carolina State Department of Public Welfare.

were available but who had been examined on the Wechsler-Bellevue or other intelligence scales are not included in the table, as I.Q.s obtained on different scales are not comparable, especially at the lower levels of intelligence. It will be noted that there is some positive relationship between social competence scores and intelligence quotients, but not a very close one.

In Table 4 a comparison is made of Social Competence

TABLE 4. COMPARISON OF WECHSLER-BELLEVUE I.Q. AND SOCIAL COMPETENCE SCORES FOR CASES REFERRED FOR CONSIDERATION BY EUGENICS BOARD *

	White Female	*Negro Female*	*White Male*	*Negro Male*	*Negro Male*
Number of cases	11	13	1	1	1
			Age	Age	Age
Average age in years	26	27	53	23	30
Standard deviation	7.5	6.7			
Average I.Q. (W-B Form I)	49	54	Army B	W-B	S-B
Standard deviation	11.9	5.3	72	34	46
Average Social			Score	Score	Score
Competence score	33	34	42	31	24
Standard deviation	10.3	4.6			
Coefficient of correlation	.50	.92			

* These figures are quoted with the kind permission of Commissioner Ellen Winston, North Carolina State Department of Public Welfare.

Inventory Scores and I.Q.s obtained on the Wechsler-Bellevue Intelligence Scale, Form I, by persons who were being referred to the North Carolina Eugenics Board for consideration for eligibility for sterilization. Since a larger proportion of these cases had been examined on the Wechsler-Bellevue Intelligence Scale than on the Stanford-Binet Scale, the latter were omitted in this table instead of the former. Again, it will be noticed that there is a positive relationship between I.Q. and Social Competence Inventory Scores. The relationship is highly positive for the female Negro cases.

In deciding whether an individual is eligible for a grant-in-aid to the permanently and totally disabled on the grounds of mental deficiency, the question of "permanence" has to be considered as well as the degree of mental and social disability. Some persons who were not mentally deficient as children may become feebleminded in later life as a result of brain damage or functional deterioration. Some of these individuals are likely to be permanently handicapped but others only temporarily so. Psychologists and psychiatrists have diagnostic tests which, used along with intelligence tests, help to determine the "permanence" or temporary nature of the mental defect. Scores on particular items and sections of the Social Competence Inventory, especially when obtained at repeated intervals, may also aid in the diagnosis of the nature of the mental handicap.

The Social Competence Inventory has been found to be of assistance to the staff members of the North Carolina State Department of Public Welfare in determining suitability for A.P.T.D. grants. It has also been found helpful to members of the Eugenics Board in determining eligibility for sterilization. Total Social Competence scores and scores on the separate sections, when taken in conjunction with intelligence test results and personal history, have helped particularly in making decisions on borderline cases.

The inventory has also been of use in connection with welfare services for old people. When it has been necessary to arrange boarding-home placement for aged men or women, scores on the Social Competence Inventory have helped workers decide upon the type of care that these people needed. Some would need close supervision and care for personal

hygiene while others, though unable to earn a living for themselves, could be trusted to keep themselves clean and go about unaided.

Summary

A standardized interview and behavior checklist for the use of professional workers in determining the social competence of adults of inferior mental ability has been briefly described. Although it yields numerical scores, it cannot be considered an exact measuring device. The scores have value only as a means of broad classification for practical purposes when the inventory is used by skilled interviewers and observers. It has been found to be helpful in determining eligibility of clients for aid to the permanently and totally disabled and also useful to one Eugenics Board, when considering requests for sterilization.

Appendix

Social Competence Inventory for Adults

Explanation and Directions

This checklist of behavior of adults is intended for the use of psychologists, medical practitioners, and social workers to aid them in estimating the social competence of handicapped, mentally retarded, or senile persons. It should be helpful in making decisions with regard to the eligibility of adults between 18 and 65 years of age who are applying for public assistance benefits under the law for grants-in-aid for the permanently and totally disabled. Social workers will find it especially useful when making plans for the care of the aged or when preparing records of cases for consideration by the Eugenics Board for sterilization.

The inventory is to be checked from direct observation and from information supplied by relatives, friends, or guardians who are well acquainted with persons under consideration and whose testimony is reliable. Care must be taken to see that ratings are not made on false evidence, whether this be given unintentionally or prompted by some definite motive. When falsification of information is suspected the inventory ratings should be discarded.

Scoring

Mark (1) and score one point for each statement which applies to the person under consideration. Mark (0) against each statement that is not true for the person and mark (?) when in doubt. If more than five items are marked (?), the total score cannot be used as an index of social competence.

The maximum score is 55. An individual who scores 50 or over has adequate social competence for normal community living. He or she is capable of social independence and self-maintenance.

A score between 40 and 50 signifies fairly adequate social competence. A person who scores within this range would be able to get along outside an institution, and probably could contribute in some measure to his or her own maintenance.

One whose score falls between 30 and 40 is partially disabled and somewhat inadequate in social competence. He or she would find self-maintenance and group competition very difficult. Some supervision would be needed.

An individual who scores between 15 and 30 has inadequate social competence for independent living. He or she would require considerable care and supervision and would be able to contribute very little to his or her own care and maintenance.

Feebleminded or physically handicapped persons who score less than 30 may be considered to be permanently and totally disabled.

Scores below 15 indicate social incompetence to the extent that full care is necessary, in a public institution, hospital, or private home.

Individuals who score below 15 on the inventory may be considered to be permanently and totally disabled.

This scoring system is tentative, pending standardization on a sample cross-section of the population. It is based partly on the mental-age equivalents of the behavior items on the Stanford-Binet Intelligence Scales, social-age equivalents on the Vineland Social Maturity Scale, and upon clinical observation and experience. Low-grade and middle-grade feebleminded persons may be considered to be permanently and totally disabled, but some high-grade feebleminded persons are only partially disabled. They may have practical abilities

and social competence considerably above the level of their intellectual capacities.

On the other hand, there are high-grade mentally deficient persons who are so socially incompetent or emotionally unstable as to be incapable of earning a living. The Social Competence Inventory should be of assistance in determining whether these borderline cases may or may not be considered to be eligible for a grant-in-aid of the permanently and totally disabled.

Name..... Birthdate..... Date.....

Case number.....Age..... Total score.....

Informant..... Recorder.....

I. *Motor Skills and Control*

The person can:

Score

.... 1. Stand without support for ten or more minutes.
.... 2. Walk a mile or more unattended.
.... 3. Write own name legibly.
.... 4. Copy a verse of "America" or write a half-page letter legibly.
.... 5. Do simple manual work at home such as digging, chopping wood, darning, sweeping, dusting.
.... 6. Do simple manual work for remuneration, such as fruit and cotton picking, car washing.
.... 7. Do semi-skilled work, such as truck or tractor driving, lathe turning, wood sawing, housecleaning, laundry work.
.... 8. Work efficiently at a skilled occupation, such as shoe mending, storekeeping, cooking, house painting.
.... 9. Drive an automobile, motorcycle, or bus.
....10. Do precise finger work, as in watch repairing, drafting, hair dressing, needlecraft, stenography, engraving, musical instrument playing.

Comments:

II. *Perception and Memory*

The person can:

Score

.... 1. Recognize traffic lights and signals: red; stop; green; go; amber; caution.
.... 2. Read road and street signs: no parking, one way, main street, etc.
.... 3. Read a newspaper column or other small print with or without glasses.
.... 4. Speak intelligibly, pronouncing words of three or more syllables and double consonants correctly.

.... 5. Count and add the white spots over six on any two standard-size black dominoes.
.... 6. Make change under a dollar; e.g., fourteen cents out of twenty-five, two cents out of a dime.
.... 7. Tell the time by clock or watch correctly to the minute.
.... 8. Hear and repeat ordinary speech four feet or more away, with or without hearing aid, e.g., repeat "There are fifty-two weeks in a year" heard across an office desk.
.... 9. Hear and repeat ordinary speech ten feet or more away without hearing aid, e.g., repeat "Christmas Day is on December twenty-fifth," heard from the end of the room.
.... 10. Make telephone calls and take messages by telephone.
.... 11. Tell own name and address on request.
.... 12. Point correctly to right and left sides of room or road.
.... 13. Turn to face north and then east when asked to do so after being shown which is the north side of the room.
.... 14. Remember practical instructions, such as shopping lists of five or more articles for several hours, long enough to execute a task assignment.
.... 15. Understand simple causality and explain what makes a door close and bang, a bicycle to go, or a cigarette to light.

Comments:

III. *Self-Care and Self-Help*

The person:

Score

.... 1. Washes and bathes self, keeping clean without supervision or assistance.
.... 2. Has ordinary bowel and bladder control, does not soil or wet clothing.
.... 3. Can dress and undress without help, fastening and unfastening buttons, press-stubs, zip fasteners and shoe laces.
.... 4. Can take a shower or sponge bath without assistance.
.... 5. Can feed self, using spoon and cup or glass unassisted.
.... 6. Uses table utensils dexterously without spilling, e.g., knife, fork, cup, glass.
.... 7. Has ordinary control of appetite, eats moderately. Neither eats to excess nor habitually refuses food to the serious detriment of health.
.... 8. Has control over drinking intoxicating beverages, does not drink to excess, causing embarrassment to others or reducing work efficiency.
.... 9. Can get on and off streetcars and buses without help or much difficulty.
.... 10. Can travel independently by any means of public transport: train, streetcar, bus, or plane.
.... 11. Can be trusted to find own way about familiar neighborhood and return within a given time. Does not wander and lose sense of direction.
.... 12. Can be trusted to go about alone in an unfamiliar neighborhood and return; would ask the way and follow directions when necessary.
.... 13. Takes care of own clothing and belongings, is not careless or destructive.
.... 14. Manages own finances, paying taxes, rent, and other bills.
.... 15. Earns a living and maintains self independently, or could do so if work were available.

Comments:

IV. *Social Relationships and Emotional Control*

The person:

Score

.... 1. Gets along well with family and friends without undue quarreling or complaining.

.... 2. Shows interest in the affairs of others, is not indifferent and withdrawn, inquires after health or others' activities.

.... 3. Does helpful things for others, is kind and considerate, shares possessions.

.... 4. Takes care of other people's belongings or public property, has not repeatedly damaged, destroyed, or confiscated the property of others.

.... 5. Joins in group enterprises; e.g., social entertainment, church affairs, choir singing, discussions.

.... 6. Plays table games, adhering to rules, such as checkers, poker, dominoes.

.... 7. Plays active games, adhering to rules, such as horseshoes, baseball, square dancing, bowling.

.... 8. Takes responsible care of younger persons during the day, catering to physical needs and habit training or giving recreational supervision.

.... 9. Assumes responsibility for the night care of children, or could do so to the extent of staying all night alone in the house with them.

.... 10. Takes full responsibility for the maintenance and care of a family.

.... 11. Has control over sexual behavior, is not a public nuisance because of perverse or other sexual excesses.

.... 12. Has control over the use of profane language, does not have outbursts of temper and profanity.

.... 13. Has control over emotional moods, does not give way to extreme depression and weeping or to noisy excitement.

.... 14. Has control over aggressive impulses, does not hurt or frighten others with violence or threats.

.... 15. Has sufficient courage and confidence to converse with strangers or visit new places unattended. Is not excessively timid.

Comments:

PARENT-CHILD COUNSELING IN A MULTIPLE SERVICE AGENCY

SAUL HOFSTEIN, D.S.W.*

IN establishing the Jewish Community Services of Long Island in 1942, its founders aimed at developing a comprehensive program which would include, in addition to the services traditionally carried by family agencies, the child guidance function. Beginning in a new agency, the first professional staff attempted to draw on the then current practice of the family and child guidance agencies. Caseloads were undifferentiated and the staff as a whole worked with cases involving disturbed behavior of children in addition to the more usual situations of family agencies. While much that was helpful derived from the experience of the family and child guidance agencies, somehow that was not enough.

The coexistence of child guidance and family services in one agency introduced certain differences which made for problem. The family agency, which today regards its responsibility for children in the family differently, then worked with family relationships primarily involving adults with the underlying assumption that, even where problem existed in the child, a change in the parents' attitudes would result in a change in the child. Where that did not happen, the family agency referred the child to a child guidance clinic. Implicit in this practice of working through parent alone seemed to be the assumption that the child had no self of his own, that he did not contribute to the problem in relationship or participate in its modification unless he was sick. The child guidance clinic, on the other hand, had as its primary concern the child, and its emphasis was on changing the child. The role of the parents was secondary, if it was admitted at all. Workers in J.C.S.L.I. carrying both marital and child guidance cases experienced confusion in their rôle. What could they offer? Where would their emphasis be? They naturally tended to deal with these cases according to their previous experience, concentrating

* At the time this article was written the author was supervisor of children's and youth services for Jewish Community Services of Long Island. He is now assistant director of the Infants Home of Brooklyn.

either on parent or child, often shifting from one to the other. Neither felt right.

As the agency experienced its dissatisfaction with the resulting service for children, it decided to bring in a part-time consultant to train staff for this specialized function. Rather than undertake to train the entire staff, the decision was made to select two workers with previous experience in children's work, one from the field of child guidance and one with a background in placement. As the consultant and the two workers began, they were at first caught up too in the dilemma and tended to stress the child guidance approach with its emphasis on the child. Gradually, however, a different conception began to emerge. The basic emphasis in service could not be adult *or* child; rather, it had to be the relationship between parent *and* child. This fundamental relationship provided the perspective from which all work with the client—whether parent or child—could be approached.

At first glance, it might be said that this relationship is similarly the primary concern of the child guidance clinic. But there is a difference. An underlying assumption in most child guidance clinics is that the child is sick or at least that his disorder is such as to require treatment by the psychiatrist. Even where the social worker sees the child, psychiatric controls are introduced and the worker with the child is referred to as the "therapist." The implication generally is that the child in difficulty must undergo a fairly extensive modification of personality to be helped. In contrast, in our agency, as the parent-child relationship became the focus of treatment, the assumption was that many children could get caught in relationship problems as well as adults and that they could be helped through casework methods to modify their role in the relationship, as could the adults. This too is different from the family agency emphasis on the parent, and referral to the child guidance clinic where that failed to change the child. Since we saw the parent-child relationship as polar, with child and parent both playing a part in whatever happened therein, we recognized the need for both to work on this in order to bring about basic change.

As we came to the conclusion that dealing with children's problems in such a setting required the development of a set

of attitudes, a basic orientation enabling the worker constantly to keep in mind the parent-child relationship whether he worked with child, parent, or both, the need to separate this function from the others in the agency became apparent. The addition of a supervisor, trained in working with parent-child relationships and the organization of a separate division within the agency was the next step. While parent-child counseling was seen as the core service of this new division, it became apparent too that a similar orientation was necessary in regard to a variety of other services involving children in their own homes. These services included direct financial assistance growing out of a child's need, referral to specialized resources for children, parent counseling either in relation to planning for a child with some special problem not amenable to treatment, or in relation to a parent's problem in carrying the parental rôle. For those children whose problems were more deeply internalized or who showed marked pathology, provision was made for diagnosis and treatment by qualified psychiatrists.[1]

Underlying the subsequent development of the Children's and Youth Services have been certain beliefs and assumptions. We have felt that problems related to children had in them a certain common element which could best be dealt with by workers especially trained and developed in the area of parent-child relationships. A further assumption has been that there is sufficient complexity and uniqueness in the kinds of problems presented in relation to children in a community agency to warrant a great degree of concentration, and that such concentration would lead to a fuller awareness of the nature of the problems dealt with as well as the development of more specialized methods of dealing with them. Implicit as well has been the belief that with a specialized division focused on service for children and parents, the agency would be in a better position to determine needs in this area, to learn about specialized resources for children available in the community, and to develop new services where necessary to meet those needs.

The availability within one agency of two distinct divisions—

[1] See Aptekar, Herbert. "The Use of Private Psychiatrists by a Social Agency." *Jewish Social Service Quarterly*, Vol. XXV, No. 10, Feb. 1944.

one in which the primary orientation is upon the adult and his relationships with other adults, the other upon parents' relationship to and responsibility for the child—introduces another factor which is of profound significance for helping. The client must make a conscious choice regarding the perspective from which he wishes to work on his problem. A basic problem in all helping is how to engage the client's will in the helping process. Whatever the diagnostic perspicacity and skill of the counselor, unless the client participates actively in whatever is undertaken to help him, the result will be minimal. The need for the client to decide where he wishes to seek help provides a beginning of such engagement which has significance throughout the counseling experience. It is not the worker who establishes the focus and the goals of treatment; it is the client. This makes possible a counseling process that is focused and can be directed at the central problem for which the client seeks help.

While, as noted above, the Children's and Youth Division offers a variety of services, to illustrate the points made thus far I should like to examine more specifically only one of those services, counseling directed at modification of the parent-child relationship. Despite all that has been written about this relationship, we still have much to learn about it. Involved in it are biological growth processes as well as social and cultural factors. It is not entered into by choice nor can it be severed at will. In addition to mother, father, and child, other siblings, relatives, and the community have their effect on it. The parent-child relationship is also profoundly influenced by the personality of each of the participants and by the relationship between mother and father and other relationships within the family. What happens to the child outside the family also has its influence. Of all relationships, that of parent and child is perhaps the most dynamic. It begins at a point of almost complete symbiosis and must move through many phases to a level where the child may establish an independent existence. It is ever–changing in nature. So complex and dynamic a relationship cannot be dealt with as a totality.

How to encompass so involved a relationship within a time-limited experience and to effect changes in it is a core problem

in the development of counseling skill in this area. Kurt Lewin has shown how complexly inter-related a particular relationship is with surrounding relationships. He has shown too how change need not be in the total complex pattern of what he has described as a psychological, social, environmental field but that change in one part of that has a significant effect upon the total constellation as well as upon its other parts. We have tried to apply this in helping parents and children where there has been disturbance in the parent-child relationship. Underlying our procedures is the belief that both child and parents possess the capacity for growth and that the parent-child relationship inherently is one which makes for growth in the child. The failure of the child to grow normally or the distortion of a normal parent-child relationship results from a blocking of the natural growth potential. In trying to help parents and children overcome whatever it is that blocks them in their relationship, we do not attempt somehow to return to the point where the blocking has occurred. Heraclitus, a long time ago, said, "Into the same river you could not step twice, for other waters are flowing." We believe that whatever this blocking may have been in the past, something is happening in the relationship at the present time which continues to create problem. It is that to which we direct ourselves.

We have tried to meet the problem of effecting change in such an intricate relationship by emphasizing certain basic elements which would permit us to work with parents and child on where the problems lie in their relationship together. Through setting up a structure which involves mother, father, and child, we have, so to speak, established within the agency a simplified replica of the parent-child relationship with which we can work. We have evolved certain procedures and practices which provide definite steps for the participants as they move into a counseling experience and give them an opportunity to bring out the attitudes and feelings which play so important a part in the perpetuation of problem.

The pattern of seeing the family members involved, whether separately or together, whether with one worker seeing both child and parents or having separate workers see them, is related closely to the way in which we deal with the parent-child relationship. The problem, as we have pointed out

above, is somehow to take hold of this relationship so as to bring out the attitudes and feelings of each participant in it. As can be seen, the task of the worker is a most complicated one. From that standpoint alone, separating the case—that is, having one worker work with parents and another with the child—although it introduces administrative problems, does make possible some simplification of the worker's role. Each worker then is enabled to concentrate on one aspect of the relationship. Naturally, close coordination between the two workers must be maintained.

Aside from the more practical considerations, there are basic psychological and casework implications in the practice of dividing parent-child counseling cases. Provision for concurrent though independent interviews for parents and children provides the means of observing and dealing directly in the actual experience of separation with the attitudes and feelings of parents and child towards being apart. One has only to see what happens as mother and child go to their respective offices to grasp the significance of the separation. Throughout the counseling experience too each worker can deal directly with their changing reactions to the separation. As parent and child come together at the end of the counseling experience, the reunion has almost always considerable symbolic significance. Where division of cases has not been administratively possible, we have found that workers have had to struggle with conflicting identifications within themselves. Often too in unseparated cases parent and child compete for the worker, and each may be inhibited in expressing feeling by the awareness that the same worker is seeing the other participant. As a result, our choice has been to have different workers see parent and child where that has been at all possible.

There are certain things that the parents must agree to in starting in parent-child counseling. Both mother and father must agree to come for regular appointments, the mother on a weekly basis and the father to a lesser but equally planned extent. They must be ready to prepare the child for coming to the agency and must agree to pay a fee consistent with their income and resources. Working on these essential questions constitutes the first step in parent-child counseling. We have also found it helpful to establish at the beginning a trial

period which permits workers and parents to test out whether this experience can be helpful. Once mutual agreement is reached to continue beyond the trial period, we have found it helpful for the agency generally to offer a definite number of sessions for parent and child. The entire parent-child counseling process usually requires fifteen to twenty sessions for each participant.

The objective here again is not to effect a total modification in the personality of the child or the parents. Rather, we attempt in this limited counseling experience to help the parents and the child face what factors are blocking them in the normal growth potential of the parent-child relationship and to help them then take steps toward the modification of those factors. Numerous follow-up interviews with clients who have finished a counseling experience have borne out our belief that once we had helped the family to begin to take hold of their problem they could continue to work on it on their own.

The procedures we have worked out too include a pattern for the father's participation. We have seen increasingly how important to the developing relationship between mother and child is the father's rôle. When about eight years ago, we began to insist that the father be part of the treatment, fathers were ready to involve themselves and to carry their share of change in their relationship to the child. Through periodic joint interviews in which mother and father meet together with their worker we stress the mutuality of responsibility for parenthood.

Our basic assumption in direct work with children is that the child has an inherent growth potential which may be blocked in one way or another. We have found accordingly that many children are capable of making use of a counseling experience that does not attempt any complete change of their basic personality. Children with serious emotional disturbance are provided treatment through our panel psychiatrists. As with parents, in our work with children we also have been developing various methods and procedures which provide for the child opportunities for choices and an experience of freedom and acceptance, accompanied at the same time by very real limits with which he will have to come to terms as he does at home and in the community. Naturally.

in such work we must take into account the psychology of childhood. Of importance in developing counseling methods are the facts that children talk a language which is different in many respects from that of adults; that they live more in projection, imagination, and fantasy then do adults; that they have less control of their impulses; and that their responses and way of functioning vary with age. Since casework has had limited experience in working with children, particularly in this type of setting, we have had to learn from practice. We have had to discern first which children could use this casework help and which would have to be referred to our psychiatric panel for treatment. We have had to come to understand the language of children and to develop means of bringing into our sessions with them the focus of our counseling service—that is, the parent-child relationship. It has been important too to recognize, come to terms with, and use the fact that in most cases the child comes, not on his own volition, but under parental compulsion.

Actually some of the problems inherent in working with children have seemed more formidable in contemplation than in practice. I think generally we did not give enough credit to children for what they were truly capable of when offered a consistent, understanding, positive experience based on trust in their own ability to use help. We have found that children were able to deal with the basic reasons for their coming and that they could express their problem and could use the help of the workers in working on it. True, they do not always express themselves in the language that adults do, but in their play and in their reactions—in what they say, for example, on the ediphone, if one happens to be available—and the words they put into other peoples' mouths, in their projections, one can find a language as understandable as that of any adult.

Much can be said about what is involved in the training of caseworkers to work with children. That is not any easy task, but we have found that caseworkers, once they have overcome their stereotyped attitudes about children and have developed an understanding of the basic parent-child relationship and of the processes through which we try to effect changes in it, are capable of learning to deal with and understand children. But our purpose here is not to discuss training.

In our development of parent-child counseling, we have retained a flexibility of approach. Our procedures have been related to a variety of family situations and problems with children. Perhaps the best way to illustrate parent-child counseling as we practice it is to tell you about one such case.

Mr. Lewis [2] called the agency initially to ask for a woman to sleep in with his child. His wife had died and he was frantic about how he could care for his 3½-year-old son. He accepted an offer to come in even though we could not meet his request. It was obvious in the interview that he was not ready really to face the loss of his wife and was unable to work out any plan which would involve actual facing of that fact. Desperate and in a state of panic initially he could take hold of himself as the worker in the two interviews helped him to examine concrete possibilities and then could recognize that the plan he had contemplated—of having just any domestic worker care for his son—would not meet the needs of his child. From that, he expressed interest in and was referred to a placement agency. At that agency, he could not accept the conditions of placement. He was not heard from further at that time.

Five years later he called the agency to ask for help with Benny, who was then living with an aunt. Benny had no friends, disregarded others, seemed to be battling him all the time, and had trouble in school. In his interview,[3] Mr. Lewis found it hard to begin but then could talk of his own unhappiness about his son and his difficulty in reaching him. It was apparent that the boy was responding through behavior to what was happening in relationship to his father and to the absence of his mother. Mr. Lewis moved from one extreme to the other. Either he would give in completely or fly into rages at Benny's behavior. The aunt with whom Ben was staying felt she had to counteract Mr. Lewis' leniency by being overly stern and throwing up at Ben constantly the fact that she was doing so much to care for him.

In many ways this case was certainly not typical of the large majority of situations we see where mother and father are both present in the home and where the child is living in that home. However, as a community agency concerned in

[2] All identifying material in this case has been modified.

[3] The workers in this case were Isidore Shapiro and Mrs. Murial Gladstein.

the welfare of children, we did feel that we had a very real responsibility. Here was a situation where father and son were moving further apart, where the son was developing really serious, anti-social behavior and becoming increasingly unhappy. As we considered this situation we felt we could still use our basic procedures as described above.

Both the father and the aunt were seen and indicated their readiness to work with us on their part in the problem while we worked with Benny. Benny was to be seen by a separate worker. During the initial trial period, Mr. Lewis at first persisted in demanding formulas for "handling his son." What should he do? How could he make Benny conform to his own needs? Denying any quick solution, the worker helped Mr. Lewis examine his own rôle in specific incidents involving Benny. In connection with these, Mr. Lewis came to recognize that his own attitudes had something to do with Ben's behavior. The aunt, on the other hand, expressed considerable antagonism towards Benny and later could talk of her feeling of being imposed upon by Mr. Lewis. As the worker related to her hostility, the aunt could get to the other side too and talk of her love for Benny, who came to her after she had seen her own children grow up. Particularly as they saw how Benny could get started with his worker, both Mr. Lewis and the aunt decided at the end of the trial period that they wanted to continue.

Benny in starting with his worker, tended to deny the existence of any problem; he was aware that he was coming because of the various troubles he was having but denied any unhappiness. He was very conforming and careful. By his third interview, he talked of his "troubles," began acting aggressively, and said that he would want to continue to try to make things better. He brought out too his conflict about his father's pending remarriage.

In all, Benny was seen 16 times, Mr. Lewis 12 times and the aunt 19 times. While initially Mr. Lewis tended to stress Benny's behavior, by his seventh interview he could, with the workers help look more at his own attitudes towards Ben. He saw that he was putting excessive demands upon Ben while at the same time not really trusting him. Slowly he came to the realization that he could not make everything good for Ben.

For instance, he had never told his son that his mother had died. He had also not involved Benny fully in his plans to remarry. Only in the middle of his contacts was he really ready to face the fact that he feared his son essentially was showing characteristics inherited from his mother and his basic concern about that. As he could begin to come to a better understanding of his son and allow his own positive feelings to come out, he found much that was good in Ben that he could trust and plan for. At the same time, he was able to take over more of the discipline of Ben.

The aunt at first put all the fault on Benny and his father. As the worker related to her feeling, she could begin to think more of her own rôle. As she saw the worker helping Mr. Lewis to take more responsibility, she could bring out more directly what it meant to her to take on a child at her age and to begin to face too some of the distrust she had of this child. She related this to her own early life experience as an orphan. Gradually she too found more that she could trust in Benny. As she reacted to Ben's growing relationship with his worker, the aunt brought in another side of her feeling, her need to keep Benny close to her. As the worker related this to Mr. Lewis's forthcoming marriage, the aunt could face her own divided feelings and bring out her fear of losing Benny. She could use the worker's help in facing what giving up Benny to his new mother would mean. As Benny himself showed more feeling for her, and as she sensed that this love would continue even after he left, she felt ready for the separation. She found a job which she would start when Benny left. The fiancee of the father came to see the worker on her own volition during the ending phase. She used her interview to gain more confidence about taking up responsibility as Benny's new mother but could also bring out all her fear of that.

Benny, after the trial period, could not talk of his troubles at first. He acted out his problem by shouting and struggling against the limits in his hours. As the worker, while holding him to the "rules," could nonetheless accept his behavior and relate it to what was happening outside, Benny spoke of his longing for his mother and his mixed feelings about his father's fiancee. The worker's acceptance of that feeling and helping him come to terms with his loss made possible Benny's talking

of his problem of "how to act with ladies" and his confusion about where he belonged. The worker could relate this to what Benny was doing with her. Was that too part of his trouble at school and with his aunt and father? Through the worker's consistent use of the natural limits of her hours with him, Benny was able to develop a greater readiness to relate himself to those limits and to move into a different kind of relationship with an adult figure, which he then could carry over to his aunt, his father, and his father's fiancee. At first there was a good deal of hostility and jealousy at the idea that someone else would be sharing his father. Gradually, however, he began to develop a positive relationship to the fiancee. In his last interview he told the worker how he planned to throw out some of his toys to make room for his new mother. In ending, he asked the worker to help him write a note: "Benny is growing up and will soon be 9." Mr. Lewis called about a month after the final interview to tell the worker he felt Benny was wonderful, though he acts up sometimes. He saw this occasional acting up as natural. He felt quite ready to take care of things and credited the agency with "bringing his family together."

Perhaps we can end on the note of this father. Our task as we conceive it in the Children's and Youth Services is to help parents make possible the fullest growth of children and to help children directly to realize their growth potential. Our trust is in the ability of children and parents really to meet the problems they must face together, once they have had help in freeing themselves from whatever blocks their natural capacities. Our conviction is that casework can develop methods and services which will make such constructive growth possible. There are many problems inherent in such help with parents and children. I have tried here to discuss a few of them. We cannot function on the assumption that we know everything that is necessary to help parents and children. Knowledge is an ever-widening spiral. As we learn, we find new areas for further study. As a division concerned with helping parents and children live together and fulfill their rôle in society, we are eager to expand our own knowledge, to test out again and again our own and other ways of working, to face the problems inherent in this field, and to develop ever-improving services for children in our community.

COHORT STUDIES OF MENTAL DISEASE IN NEW YORK STATE, 1943 TO 1949*

BENJAMIN MALZBERG, PH.D.
New York State Department of Mental Hygiene

PART I

IT was accepted as a fact, for many years, that the average duration of residence in a mental hospital was about five and a half years. It appears, upon examination, that this figure probably was obtained by averaging the total duration of residence, excluding time in convalescent care, of patients who died in state hospitals for mental disease. Obviously, this procedure could not be correct, for it did not include the corresponding data for patients who did not die but were discharged back to the community. There was an apparent implication that the duration of residence was the same, whether patients left the hospitals by death or by discharge. But even if both were included in the average duration of residence, there would still be a fallacy in the reasoning because it excludes those patients who were in the hospitals at the end of specified periods. In a closed system, in which patients must all ultimately be discharged or die, the average duration of residence could be obtained by a consideration of these two groups. In an actual system of mental hospitals, such a procedure is not possible. The population that remains in the hospitals must always be considered. Therefore, another procedure must be adopted in order to determine the distribution of periods of hospital residence. Instead of beginning with a population made up of discharges and deaths, we must reverse the order of observation and begin with a group of hospital admissions within a specified period, the members of which must all be observed subsequently for equal durations of time. Within each of these intervals, there is recorded the number of patients who leave, die, or remain at the end of the interval.

* This is the first of a series of eight or nine reports based on an investigation supported by a research grant from the National Institute of Mental Health, of the National Institutes of Health, United States Public Health Service.

Such a population is called a cohort, and by following the history of each member of the cohort it is possible to obtain data from which one may derive correct rates of discharge, of mortality, and of average duration of residence in mental hospitals.

The preparation of such cohorts was made possible for the New York civil state hospitals through the introduction April 1, 1943 of a system of statistical recording on punched cards. These cards were prepared for every patient admitted to a mental hospital after that date, and a corresponding card was prepared when the patient was discharged or died. If the patient was readmitted, the process was repeated, and all the punched cards for each patient were brought together and filed chronologically.

At the beginning of this investigation, the statistical files included punched cards for all first admissions, discharges, and deaths from April 1, 1943 through March 31, 1949. First admissions during the fiscal year which began April 1, 1943 and ended March 31, 1944 were thus followed from the date of admission to March 31, 1949. The maximum period during this interval was six years; patients admitted at the end of this fiscal year could be followed for only five years. Because it is necessary that each member of the cohort have the same period of exposure, none could be followed for a period greater than the minimum for the group, namely five years. Therefore, each member of this cohort was followed for five years from the date of first admission. The same principle was applied to those admitted during each of the next four fiscal years, the period of exposure being reduced successively by a year. Thus, those admitted during the final fiscal period selected for this study (April 1, 1947 to March 31, 1948) were exposed for a period varying from one to two years, ending March 31, 1949. But to secure a uniform period for each member of the cohort, the period of observation had to be one year from the date of first admission for each member of the cohort. The periods of exposure varied, therefore, from a minimum of one year for those admitted during the year ending March 31, 1948 to five years for those admitted during the year ending March 31, 1944.

During the five fiscal years which began April 1, 1943 and ended March 31, 1948 there were 88,126 admissions to the New York civil state hospitals. These included 66,348 first admissions (that is, they had had no previous admission to a mental hospital). From these first admissions, there were excluded 1,775 who were transferred to or readmitted subsequently to a mental hospital which was not a part of the state hospital system. We were thus left with a total of 64,573 first admissions, 30,287 males and 34,286 females. Table 1 summarizes the five cohorts by year of first admission.

TABLE 1. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, FISCAL YEARS 1943–1944 TO 1947–1948, INCLUSIVE

Fiscal Year	*Males*	*Females*	*Total*
1943–1944	5,829	6,827	12,656
1944–1945	5,554	6,537	12,091
1945–1946	5,765	6,715	12,480
1946–1947	6,228	6,813	13,041
1947–1948	6,911	7,394	14,305
Total	30,287	34,286	64,573

Of the 64,573 first admissions, all but 10,058 (15.6 percent) were included in seven groups of mental disorders. The largest was dementia praecox, which included 16,571 cases (25.7 percent of the total). Psychoses with cerebral arteriosclerosis totaled 14,370 (22.3 percent), and the senile psychoses included 10,666 (16.5 percent). The two latter groups included 38.8 percent of the total first admissions. Together with dementia praecox, these three groups included almost two-thirds of the total first admissions. The complete distribution according to mental disorders is shown in Table 2.

A further classification is shown in Table 3 with respect to age at first admission.

The weighting with the aged is clearly evident. Of the 64,573 first admissions, those aged 70 years or over totaled 17,210 (26.7 percent). If we assume age 60 as the cutting-off point, then we include 26,424 (40.9 percent), as the group of advanced age. As is well known, first admissions of advanced age have been increasing steadily for several decades and now represent a major problem in state mental hospitals.

Though on a far smaller scale, attention must also be direc-

TABLE 2. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, FISCAL YEARS 1943–1944 TO 1947–1948, INCLUSIVE

(Classified According to Mental Disorders)

	Number *			*Percent*		
Mental Disorders	Males	Females	Total	Males	Females	Total
General paresis	2,140	783	2,923	7.1	2.3	4.5
Alcoholic	2,497	832	3,329	8.2	2.4	5.2
With cerebral arteriosclerosis	7,271	7,099	14,370	24.0	20.7	22.3
Senile	4,209	6,457	10,666	13.9	18.8	16.5
Involutional	1,200	2,982	4,182	4.0	8.7	6.4
Manic-depressive	745	1,729	2,474	2.4	5.0	3.8
Dementia praecox	6,841	9,730	16,571	22.6	28.4	25.7
Other	5,384	4,674	10,058	17.8	13.6	15.6
Total	30,287	34,286	64,573	100.0	100.0	100.0

* Excluding those who were subsequently transferred to a licensed hospital.

ted to the youngest age group, those under 15. This group included 819 first admissions, of whom more than half were males. The group consisted primarily of those diagnosed as having behavior disorders, including a variety of emotional problems. It is only in recent years that this group has begun to show significant totals in admissions to the New York civil state hospitals.

TABLE 3. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, FISCAL YEARS 1943–1944 TO 1947–1948, INCLUSIVE

(Classified According to Age)

	Number			*Percent*		
Age (Years)	Males	Females	Total	Males	Females	Total
Under 15	592	227	819	2.0	0.7	1.3
15–19	1,346	1,212	2,558	4.4	3.5	4.0
20–24	1,789	2,029	3,818	5.9	5.9	5.9
25–29	1,786	2,406	4,192	5.9	7.0	6.4
30–34	1,895	2,607	4,502	6.3	7.6	7.0
35–39	1,989	2,589	4,578	6.6	7.6	7.1
40–44	2,083	2,360	4,443	6.9	6.9	6.9
45–49	2,003	2,320	4,323	6.6	6.8	6.7
50–54	2,082	2,358	4,440	6.9	6.9	6.9
55–59	2,243	2,093	4,336	7.4	6.1	6.7
60–64	2,372	2,066	4,438	7.8	6.0	6.9
65–69	2,396	2,380	4,776	7.9	6.9	7.4
70 or over	7,650	9,670	17,210	25.3	27.9	26.7
Unascertained	61	79	140	0.2	0.2	0.2
Total	30,287	34,286	64,573	100.0	100.0	100.0

This study will deal with the proportions of events (discharges, deaths, etc.) that occur within specified periods after first admission to the New York civil state hospitals. It is therefore necessary to define how we measure these periods. The interval has been taken usually as from the date of first admission to the date when the patient left the hospital, either by immediate discharge, by placement in convalescent care (parole), or by death. This is appropriate from an administrative viewpoint, since it is related directly to such problems as the availability of beds and expenditures for maintenance. The duration of hospital residence is also of deep concern to the patient and his family, since it represents time when he is limited in varying degree with respect to personal liberty.

We are also interested, however, in the question of the duration of a mental disorder. With this in mind, placement in convalescent care cannot be considered a suitable end-point. Psychotherapy is administered during the convalescent period. Various somatic therapies are also applied during this period. Thus, placement in convalescent care must be considered part of the entire treatment procedure.

The standards for placement in convalescent care may remain relatively constant in a given hospital. In a hospital system, however, the duration of the interval prior to such placement varies from hospital to hospital. Patients have short or long residences depending, in part, upon the attitudes of hospital administrators towards the use of convalescent care. This is an important consideration, because though 70 percent of patients are discharged by the New York civil state hospitals while in convalescent care, the percentage varies among the several hospitals from a minimum of 30 percent to a maximum of 85 percent.

Furthermore, from 30 percent to 40 percent of the patients placed in convalescent care subsequently return to the hospitals because of an exacerbation of the same illness. They pass back and forth from the status of in-patient to that of out-patient.

For these reasons, and because it is related more directly to the concept of the "natural history" of a disease, the interval employed in the following analysis begins with the date of first admission and ends with removal from the books, either

by discharge or by death. The majority of the patients so discharged were removed from the books while in convalescent care. However, a substantial number, almost 30 percent, were discharged directly from the hospitals.

Included in this study were 64,573 first admissions to the New York civil state hospitals. Of this total, 12,656 were followed for a period of five years from the date of their first admission, which occurred during the year ending March 31, 1944. Discharges from this group occurred during each of the five years ending in the fiscal year 1948–1949. The 12,091

TABLE 4. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DISCHARGED DURING SPECIFIED PERIODS AFTER ADMISSION

(Classified According to Percentage and Rate)

Period of Hospitalization	*Males*			*Females*		
	Percent	Cumulative Percent	Rate per 1,000 Exposures*	Percent	Cumulative Percent	Rate per 1,000 Exposures*
First three months.	9.5	9.5	453.4	6.7	6.7	309.2
Second three months	2.5	12.0	146.3	2.0	8.7	108.3
Third three months	1.3	13.3	84.6	1.0	9.7	57.4
Fourth three months	1.1	14.4	65.8	0.8	10.5	49.9
First year	14.4	14.4	166.5	10.5	10.5	119.8
Second year	21.5	35.9	395.4	26.5	37.0	429.1
Third year	3.8	39.7	134.2	4.2	41.2	136.0
Fourth year	1.6	41.3	74.1	1.6	42.8	66.7
Fifth year	0.7	42.0	36.4	0.7	43.5	32.9

* On an annual basis.

admitted during the fiscal year ending March 31, 1945 could be followed for a maximum of only four years. Thus, though this cohort contributed to the discharges of each of these years, it could not be included in discharges during the fifth year. In a similar manner, no discharges were recorded during the fourth year after admission from among the first admissions during the year 1945–1946. Finally, those admitted during 1948–1949 were followed for only one year and therefore did not contribute to the total of discharges during the subsequent years. Therefore, since each of the five cohorts was followed during the first year, the total discharges must be related to the total admissions or exposures during that period. However, discharges during the second year must be related only to the first four cohorts, since the final cohort (1947–1948)

the first year. Beginning with a rate of 309.2 per 1,000 exposures during the first quarter, the rate decreased to 49.9 during the final quarter of the first year, with an average of 119.8 for the first year. The rate increased to 429.1 during the second year and then fell rapidly to 32.9 during the fifth year.

Because of the different methods of recording duration of hospitalization, the rates of discharge during the first year cannot be compared with those of the earlier cohort. By the end of the second year, however, discharges were comparable, representing in both cases discharges from the books. On this basis, the discharge rates for males within two years after hospitalization were 430 and 388 per 1,000 among the current and early cohorts, respectively. For the females, they were 437 and 352, respectively.[2] As noted previously, however, the rates for the cohorts of 1944 to 1948 must be reduced by a fifth, because of different methods of recording, in order to make them comparable with the older cohort. It then follows that there were no significant differences in rates of discharge. This must be ascribed to the higher proportion of first admissions of advanced age among the current cohorts.

The discharges varied inversely with the age at first admission. Thus, 33.3 percent of males aged less than 15 years at first admission were discharged within a year after hospitalization. The percentage discharged within this period decreased steadily with advancing age, reaching 20.3 percent among those aged 40 to 44 at admission and 11.8 percent among those aged 55 to 59. At older ages, the discharge rate decreased even more rapidly, dropping to 3.3 percent among those aged 70 years or over at admission. A similar trend was shown in every period of hospitalization from the date of first admission. During the first quarter of the first year, for example, the percentage of discharges declined among males from 9.0 among those aged less than 15 years to less than 1 percent among those aged 65 or over at admission. Because of the predominance of certain diagnostic groups, 33.3 percent of first admissions aged less than 15 years at admission were discharged during the first year, compared with only 16.0 percent during the second year. At subsequent ages, however, the percentage of those discharged during the second year declined steadily from a maximum of 37.3 percent at

TABLE 5. PERCENT OF FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DISCHARGED DURING SPECIFIED PERIODS AFTER ADMISSION
(Classified According to Age at First Admission)

Age at First Admission (Years)	*Males*									*Females*								
	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	2nd year	3rd year	4th year	5th year	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	2nd year	3rd year	4th year	5th year
Under 15 ...	15.0	9.0	7.1	2.2	33.3	16.0	9.9	4.8	3.3	10.6	4.0	1.3	1.3	17.2	21.4	15.6	8.4	7.0
15–19	15.6	5.3	3.6	2.5	27.0	37.3	8.9	2.9	1.2	10.8	5.1	2.6	1.3	19.9	42.3	9.2	2.8	2.2
20–24	15.8	6.5	2.6	2.2	27.2	34.1	6.9	3.5	1.7	11.2	5.1	2.1	1.5	20.0	45.3	6.2	2.6	1.0
25–29	17.5	4.8	3.0	1.6	26.9	34.7	6.2	2.2	1.3	11.0	4.6	2.0	1.6	19.2	41.3	7.2	2.4	0.4
30–34	16.6	4.0	2.0	1.7	24.3	36.2	6.7	3.1	1.6	11.1	3.7	2.0	0.9	17.6	43.0	6.2	3.2	1.0
35–39	15.9	3.3	1.5	1.6	22.3	34.3	5.9	2.4	1.1	10.0	3.1	1.4	1.0	15.6	41.9	6.7	2.0	1.3
40–44	14.8	3.4	1.1	1.1	20.3	34.0	5.3	2.1	1.2	9.7	2.3	0.9	0.8	13.6	41.8	5.7	1.8	0.9
45–49	12.8	2.9	1.2	0.9	17.9	30.9	5.8	1.9	0.8	7.4	1.8	1.2	0.9	11.3	37.0	6.1	2.6	1.0
50–54	10.1	2.3	1.0	0.7	14.2	26.9	4.5	0.9	0.5	7.7	1.7	1.1	0.8	11.3	35.4	4.9	1.8	1.2
55–59	8.3	1.8	1.0	0.6	11.8	23.8	3.9	1.6	0.2	6.3	1.1	0.5	0.9	8.7	28.4	5.0	2.4	0.2
60–64	5.2	1.1	0.9	0.6	7.8	16.3	2.1	1.4	0.2	4.8	0.6	0.6	1.0	7.0	19.8	3.6	0.6	0.2
65–69	4.4	0.3	0.4	0.4	5.6	11.8	1.9	1.2	...	3.4	0.5	0.5	0.8	5.3	13.2	2.2	0.7	0.2
70 or over ..	2.2	0.4	0.3	0.3	3.3	4.0	0.4	0.3	0.1	2.1	0.4	0.2	0.3	3.0	4.2	0.4	0.2	0.2

TABLE 6. RATES OF DISCHARGE * AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DURING SPECIFIED PERIODS AFTER ADMISSION

(Classified According to Age at First Admission)

Age (Years)	Males									Females								
	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year
Under 15 ..	605.8	425.7	377.5	129.3	334.4	261.3	233.1	143.9	120.0	424.6	179.8	62.8	64.1	173.3	274.8	274.0	207.8	250.0
15–19	627.7	253.0	182.8	135.8	271.3	522.7	261.2	112.8	52.2	435.2	231.7	127.0	65.6	199.8	536.9	255.3	98.1	80.6
20–24	640.3	316.4	138.4	122.2	274.8	489.0	198.3	125.8	63.7	456.4	236.1	101.5	77.1	201.9	583.0	187.1	101.0	43.0
25–29	710.4	239.1	157.7	90.1	272.9	490.4	169.8	93.4	46.5	444.8	208.8	96.4	80.5	193.9	532.0	200.4	86.4	18.7
30–34	673.4	198.0	104.8	91.2	247.0	507.9	191.6	107.8	68.4	451.8	170.8	95.2	44.1	179.0	552.8	183.0	124.8	44.4
35–39	662.9	170.5	81.9	89.6	231.9	495.3	174.1	91.6	41.7	408.1	144.6	69.0	51.4	159.2	533.8	188.6	67.4	47.1
40–44	626.2	173.0	60.1	59.0	212.8	494.7	163.4	80.4	54.3	403.3	107.6	43.3	39.9	141.9	529.1	157.6	63.0	34.6
45–49	552.3	150.8	69.2	54.6	192.4	465.8	177.2	73.7	32.6	314.3	83.4	59.1	45.5	119.0	479.4	157.7	87.1	39.1
50–54	451.7	123.0	57.4	42.5	156.5	419.4	133.3	34.6	22.7	332.6	83.3	56.3	42.5	121.2	486.9	142.4	64.9	45.4
55–59	385.7	101.3	58.6	39.2	134.8	405.7	129.4	74.4	13.7	284.2	54.2	28.3	50.9	97.8	423.2	140.0	83.5	9.8
60–64	254.6	61.6	58.6	42.9	94.1	306.7	68.8	60.9	11.4	232.5	32.8	37.7	64.2	83.1	342.4	107.1	23.6	10.6
65–69	233.8	21.5	29.4	35.0	71.7	255.2	70.4	58.2	...	174.6	33.1	33.0	55.9	65.7	262.0	73.1	32.3	11.8
70 or over ..	141.8	41.8	28.2	29.2	47.7	138.1	28.1	23.2	8.6	120.8	32.3	15.1	25.8	41.4	121.6	22.5	14.9	13.7

* Per 1,000 annual exposures.

† On an annual basis.

ages 15 to 19 to a minimum of 4 percent among those aged 70 or over. Discharges were few after the second year. Nevertheless, each period showed the same declining trend in relation to advancing age at time of hospitalization. During the third year, discharges decreased from 9.9 percent at ages under 15 to 0.4 percent at ages 70 or over. During the fourth year, the percent discharged declined from 4.8 to 0.3. During the fifth year, the percent declined from 3.3 to 0.1.

Female first admissions showed the same trend as males. During the first three months after admission, the percentages discharged decreased from 10.6 in the youngest age group to 2.1 among the oldest. During the first year, the percentages declined from close to 20 percent at the youngest ages to 3 percent among those aged 70 or over. During the second year, the percentages declined from over 40 percent at the youngest ages to 4 percent at the oldest. During the fifth year, they declined to less than 1 percent.

A further description of the inverse relation between rates of discharge and age at first admission is shown in Table 6. This table summarizes the *probability* of discharge during each period subsequent to admission, these being further classified according to age at admission. Rates of discharge were highest during the first three months after admission. But they declined among males during this interval from over 600 per 1,000 annual exposures to less than 200 in the older age groups. For the entire first year, the rates declined from over 300 per 1,000 annual exposures among those aged less than 15 years at admission to less than 100 among those aged 60 or over. Each subsequent period after admission to the hospitals showed similar declines in rates of discharge with advancing age at time of admission.

Females showed the same trend as males with respect to the inverse relation between age at first admission and subsequent rates of discharge. During the first year after first admission, females showed smaller probabilities of discharge than males. However, these probabilities declined from approximately 200 per 1,000 annual exposures at the youngest ages to less than 100 at the oldest ages. During the second year after admission, the probabilities of discharge were highest, but they declined from over 500 per 1,000 annual exposures at

TABLE 7. PERCENT OF FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DISCHARGED DURING SPECIFIED PERIODS AFTER ADMISSION
(Classified According to Duration of Mental Disease Before Admission)

Duration of Mental Disease before Admission	*Males*									*Females*								
	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	2nd year	3rd year	4th year	5th year	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	2nd year	3rd year	4th year	5th year
Less than one month ...	17.5	2.0	1.7	1.2	22.4	28.7	4.0	1.6	0.6	10.1	2.2	1.0	1.2	14.4	40.1	5.8	1.5	0.4
1– 3 months.	8.7	2.3	1.0	1.0	12.9	27.0	4.4	2.1	0.7	7.5	2.2	1.1	1.0	11.8	36.9	4.6	2.0	1.0
4– 6 months.	8.9	2.8	1.2	0.8	13.7	24.2	4.3	1.8	0.2	8.7	2.8	1.3	0.9	13.7	31.1	4.5	1.6	0.6
7–11 months.	10.6	3.7	2.2	1.9	18.4	21.1	3.4	1.7	0.4	7.7	3.0	1.0	1.1	12.7	28.4	3.9	2.6	0.9
1 year	7.2	2.4	1.6	0.8	12.1	19.2	3.6	1.5	0.6	5.7	2.0	1.1	0.7	9.4	22.1	3.1	1.7	0.9
2 years	6.8	2.6	1.7	0.7	11.8	16.0	4.1	1.3	0.6	4.8	2.0	0.6	0.6	8.1	16.5	3.7	1.7	0.9
3 years	7.6	2.8	2.1	0.9	13.3	13.9	3.4	2.0	1.4	4.7	1.9	0.9	0.7	8.2	15.1	3.4	2.1	...
4 years	5.9	3.9	0.7	0.7	11.3	16.3	6.3	1.6	1.3	3.8	1.1	1.1	0.9	7.0	15.4	5.0	0.9	...
5 years or over	8.0	2.9	1.2	1.0	13.2	14.9	3.6	1.3	0.8	4.7	1.0	0.6	0.4	6.7	14.2	3.6	1.0	0.7

the youngest ages to less than 120 at age 70 or over. As shown previously, rates of discharge declined after the second year of hospital life, but in each period the rate of discharge was higher among the younger than the older admissions.

There is a similar inverse relation between rate of discharge and the estimated duration of the mental disease prior to admission to the hospital. Two qualifications must be made, however. In the first place, estimates of the duration of a disease cannot be as reliable as statements of chronological age. Consequently, the indices of discharge in relation to prior duration of a disease do not show the same degree of regularity of trend. Nevertheless it is clearly evident (see Table 7) that the percentage discharge during the first and second year after admission to the hospitals was highest among those with short prior durations and lowest among those with long durations. The trend was especially evident among the female admissions.

A second qualification relates to rates of discharge after the second year of hospitalization when these are correlated with the prior duration of the disease. There was little, if any, variation of rates of discharge during these periods when they were related to the prior duration. It has been shown that rates of discharge are, in general, low after the second year of hospitalization. A longer or shorter history of disease therefore has little effect upon the outcome after a long period of hospitalization, since the groups have all become chronic.

Table 8 provides a further description of the relation of discharge to the duration of the disease before hospitalization. This table gives rates (probabilities) of discharge per 1,000 annual exposures during each period subsequent to hospitalization, correlated with the prior duration of the disease. During the first two years after admission, the rates of discharge were clearly greater for those with short previous histories, and they became smaller as the prior duration increased. This was especially evident among females. The duration of the mental disorder was unascertained in a large proportion of the cases, especially among the males. However, if it were assumed that all unknown cases belonged to

TABLE 8. RATES OF DISCHARGE* AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DURING SPECIFIED PERIODS AFTER ADMISSION

(Classified According to Duration of Mental Disease Before Admission)

Duration of Mental Disease before Admission	*Males*									*Females*								
	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year
Less than one month ...	810.0	125.2	111.0	87.1	252.5	543.4	187.1	101.1	42.7	450.8	114.8	52.9	68.7	158.1	601.6	238.4	89.6	26.4
1– 3 months	408.9	127.4	60.7	60.7	147.6	455.3	156.4	102.3	40.4	342.2	115.1	62.1	55.9	131.3	560.3	171.8	97.6	56.9
4– 6 months	420.7	163.5	75.4	51.1	157.4	432.2	160.8	87.6	10.3	389.4	145.7	73.4	52.8	151.8	494.1	159.7	74.6	31.6
7–11 months	484.8	208.6	133.4	123.7	207.1	383.1	114.9	69.3	24.1	347.6	160.3	57.7	63.9	143.0	457.4	132.6	113.9	33.3
1 year	351.3	146.5	103.7	55.2	143.1	365.1	133.8	78.1	36.4	264.7	105.6	64.5	42.0	109.2	364.2	124.7	63.2	35.7
2 years	331.6	153.1	114.6	54.4	143.0	334.7	154.4	66.4	37.7	231.1	113.8	35.3	39.9	95.4	291.8	108.4	63.2	37.7
3 years	370.4	614.0	138.3	60.1	157.6	277.3	112.1	85.9	78.9	223.9	106.0	53.7	43.6	96.7	263.5	99.6	80.3	...
4 years	283.3	224.7	49.1	51.4	134.2	325.2	217.1	73.2	58.8	178.2	62.1	67.3	57.0	82.2	260.6	133.3	32.1	...
5 years or over	382.7	165.6	76.4	69.7	153.5	276.3	104.8	47.7	33.1	216.7	53.4	35.6	22.4	77.6	225.8	84.8	27.7	20.2

* Per 1,000 annual exposures.

† On an annual basis.

TABLE 9. DISCHARGES AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, FISCAL YEARS 1943–1944 TO 1946–1947, INCLUSIVE, WITHIN TWO YEARS AFTER ADMISSION
(Classified According to Condition at Discharge)

Condition at Discharge	*Males*			*Females*			*Total*		
	Number	Percent of Total Discharges	Percent of First Admissions	Number	Percent of Total Discharges	Percent of First Admissions	Number	Percent of Total Discharges	Percent of First Admissions
Recovered	2,906	34.8	12.4	3,923	39.2	14.6	6,829	37.2	13.6
Much improved..	2,582	30.9	11.0	3,309	33.1	12.3	5,891	32.1	11.7
Improved	1,822	21.8	7.8	1,992	19.9	7.4	3,814	20.8	7.6
Unimproved	659	7.9	2.8	630	6.3	2.3	1,289	7.0	2.6
Without psychosis	392	4.7	1.7	141	1.4	0.5	533	2.9	1.1
Total discharges.	8,361	100.0	35.8	9,995	100.0	37.2	18,356	100.0	36.5
Total first admissions	23,376	.....	....	26,892	.....	....	50,268	.....	....

the category of a prior duration of more than five years, the rate of discharge would still be less than that shown by first admissions with histories of short prior durations.

Table 9 summarizes the condition of the patients at time of discharge. The interval was taken as two years after admission. This period was chosen because it has been shown that the two years following admission are the crucial periods. Thereafter, we are presented with a residue of patients who are largely chronic. In addition, it was necessary to exclude the cohort of 1947–1948, since this group had an experience of only one year.

The remaining four cohorts included 50,268 first admissions. Of this total, 18,356 (36.5 percent) were discharged within two years after admission. Those discharged as recovered represented 13.6 percent of the total first admissions. Those who were much improved and improved represented 11.7 percent and 7.6 percent respectively. The total with some degree of improvement therefore represented 32.9 percent. The sex differences, though small, favored the females. Rates of recovery were 12.4 percent and 14.6 percent for males and females, respectively. Corresponding percentages for all degrees of improvement were 31.3 and 34.3, respectively. These all exceed corresponding percentages for the early cohort. For the latter, all degrees of improvement showed the following percentages: males, 26.7; females, 24.1; both sexes, 25.4.[3]

Mortality

As explained in the previous sections, all the cohorts were exposed to a follow-up of at least one year after admission to the hospitals. In each subsequent year, one cohort dropped out of the total of exposures, until only one cohort, that of 1943–1944, remained through the fifth year. Therefore, the mortality during each year of hospital residence must be related only to the cohorts who were exposed to the risk of death during the corresponding period. The measures of mortality are therefore an average for each period subsequent to the dates of first admission.

Among males, the deaths averaged 27.4 percent of the total admissions during the first year. This was, by far, the period of heaviest mortality. The percentage of patients dying dur-

ing the entire period of five years grew to only 39.0, an addition of only 11.6 percent during four years. Within the first three months after admission, the mortality averaged 18.0 percent of the total admissions. The percentage of mortality decreased rapidly thereafter.

Females had lesser mortality than males throughout the five years. Of the total first admissions, 15.4 percent died within three months. The percentage grew to 24.4 by the end of the first year, compared with 27.4 percent for males. Only 5 percent of the females died during the second year after admis-

TABLE 10. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DYING DURING SPECIFIED PERIODS AFTER ADMISSION
(Classified According to Percentage and Rate)

	Males			*Females*		
Period of Hospitalization	Per-cent	Cumulative Per-cent	Rate per 1,000 Exposures*	Per-cent	Cumulative Per-cent	Rate per 1,000 Exposures*
First three months.	18.0	18.0	786.1	15.4	15.4	652.8
Second three months	4.5	22.5	256.6	4.3	19.7	223.4
Third three months.	2.8	25.3	176.3	2.7	22.4	157.5
Fourth three months	2.1	27.4	142.1	2.0	24.4	120.4
First year	27.4	27.4	296.2	24.4	24.4	257.9
Second year	4.8	32.2	103.4	5.0	29.4	98.8
Third year	3.1	35.3	109.3	2.9	32.3	94.2
Fourth year	2.1	37.4	96.7	2.1	34.4	84.9
Fifth year	1.6	39.0	88.6	1.6	36.0	74.0

* On an annual basis.

sion. By the end of the fifth year, 36.0 percent had died, compared with 39.0 percent of the males.

The preceding percentages are directly comparable with those for the early cohort, since they are all based upon deaths occurring in the hospitals. Of the early male cohort, 34.8 percent died within five years, compared with 39.0 percent of the current male cohorts. Among females, the corresponding percentages were 30.5 and 36.0, respectively.[4] At every period subsequent to admission to the hospitals, the current cohorts had greater mortality. As with discharges, this resulted from the greater prevalence of the psychoses of old age among the current cohorts.

The actual risks of mortality, however, can only be shown by relating deaths, not to the total first admissions, but to the

number who were exposed to such risk during each period. Since the population under exposure was reduced steadily, both by previous discharges and by previous deaths, the absolute number of deaths would necessarily be smaller in successive periods unless there had been considerable increases in the rates of mortality. When expressed in terms of deaths per 1,000 annual exposures, the results were as follows. The heaviest mortality among males, 786.1 per 1,000 annual exposures, occurred during the first three months after hospitalization. The rate dropped rapidly during the remainder of the first year, and averaged 296.2 for that period. The rate decreased by 65 percent during the second year of hospitalization, and continued to decrease, reaching a minimum of 88.6 during the fifth year.

Among females, the trend of the death rates per 1,000 annual exposures was similar to that for males. Mortality was heaviest during the first three months, averaging 652.8 per 1,000 annual exposures. The rate then decreased to 120.4 during the final quarter of the year, and averaged 257.9 for the entire year. The corresponding rate for males during the first year was 296.2. The rate decreased rapidly to 98.8 during the second year, and was 74.0 during the fifth year. Even in this period of relatively low mortality, the rate for males exceeded that for females by 20 percent.

These death rates may be compared with corresponding rates for the early cohort.[5] During the first three months of hospitalization, the early male cohort had a rate of 677.7, compared with 786.1 for the current cohort. For the first year, the average rates of mortality were 248.2 and 296.2, respectively. In every period of hospitalization, the current cohort had a higher rate of mortality, ending with a rate of 88.6 during the fifth year, compared with 40.2 for the early cohort.

Rates of mortality were lower for females than for males, but throughout the entire period of hospitalization the rates for the early female cohort were lower than those for the current cohorts. During the first three months, the rates were 469.4 and 652.8, respectively. During the first year, they averaged 211.9 and 257.9, respectively. During the fifth year, they were 68.6 and 74.0, respectively. The higher death rates of the current groups were due primarily to the great increase of

the number of older admissions, who have higher death rates than other groups with mental disorders.

It was shown in the preceding sections that rates of discharge varied inversely with age at first admission. The older the admissions, the lower the rate of discharge. Mortality, on the other hand, increased directly with age. Thus, the older the first admissions, the greater the mortality.

Table 11 shows the percentage of first admissions who died in successive periods after hospitalization, classified according to age at admission. In every age group, the highest percentages occurred during the first year. In each period since first admission, however, the percentage increased from the youngest to the oldest groups at time of admission. Among males, the percentage dying during the first three months after admission increased from less than one percent at the youngest ages to more than 40 percent at ages 70 or over. During the first year, they grew from one percent to over 60 percent with advancing age at first admission. The percentages of deaths after the first year were low, but nevertheless they too showed the same rising trend with increasing age at first admission. During the second year after hospitalization the percentages increased from less than one percent to nine percent, in accordance with increasing age. Among females, the percentage of patients dying during the first year of hospitalization varied from one percent and two percent at the younger ages to 55 percent among those who were admitted at ages 70 or over. Each period of hospitalization showed a similar rising trend from minimum percentages of those dying among the younger admissions and maximum percentages at the older ages.

We may consider next the actual rates of mortality per 1,000 annual exposures. These were highest during the first three months of hospitalization. During this period, they rose for males from approximately 40 per 1,000 among those aged less than 20 at time of first admission to 886.8 among those aged 60 to 64. At higher ages, the total cohort would have died in less than a year after hospitalization, if the rate for the first quarter had continued throughout the year. During the first year, the average death rate for that period grew from 12.2 to 627.7 in accordance with increasing age at first admission. During the second year of hospitalization, the death rates increased from 4.2 to 288.9.

TABLE 11. PERCENT OF FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DYING DURING SPECIFIED PERIODS AFTER ADMISSION
(Classified According to Age at First Admission)

Age at First Admission (Years)	*Males*									*Females*								
	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	2nd year	3rd year	4th year	5th year	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	2nd year	3rd year	4th year	5th year
Under 15 ...	0.8	...	...	0.2	1.0	0.2	0.6	0.4	...	0.4	0.9	...	0.4	1.8	...	...	1.1	...
15–19	0.7	0.4	0.1	0.1	1.2	0.4	0.4	0.4	0.4	0.7	0.2	...	...	0.9	0.4	0.4	0.2	...
20–24	1.3	0.2	0.2	0.1	1.8	0.6	0.3	...	0.3	1.7	0.2	0.1	0.2	2.3	0.4	0.6	0.3	0.5
25–29	1.5	0.4	0.5	0.2	2.6	0.7	0.4	0.2	0.6	1.1	0.4	0.2	0.3	2.0	0.7	0.6	0.3	0.4
30–34	1.8	0.7	0.4	0.4	3.4	0.4	0.5	1.1	0.6	2.1	0.7	0.3	0.2	3.3	0.5	0.8	0.9	0.6
35–39	4.7	1.8	0.7	0.3	7.4	1.6	1.2	0.4	0.5	2.7	0.9	0.6	0.2	4.4	0.9	0.4	0.5	0.2
40–44	6.3	1.3	0.8	0.7	9.2	2.2	1.6	0.2	0.4	4.8	0.6	0.6	0.6	6.5	1.6	0.9	0.4	0.7
45–49	8.1	2.6	1.6	1.4	13.7	3.0	1.0	0.8	...	6.4	1.6	1.3	0.9	10.2	1.6	1.0	1.3	1.0
50–54	11.7	3.7	2.3	1.3	18.9	3.6	3.8	1.4	1.5	8.8	2.4	1.4	1.4	13.9	3.0	1.4	1.9	1.2
55–59	15.4	4.5	3.3	2.1	25.4	4.1	2.6	1.9	1.8	13.6	2.9	2.3	2.3	21.1	4.8	3.1	1.6	2.2
60–64	21.2	5.9	3.9	3.2	34.2	7.2	4.7	3.5	1.8	20.1	4.9	3.3	2.7	31.0	5.6	4.4	2.1	2.6
65–69	27.8	6.6	4.8	3.5	42.7	8.7	5.7	3.6	3.4	24.1	7.3	4.0	3.4	38.8	8.8	4.9	3.3	2.4
70 or over ..	41.8	9.7	5.8	4.5	61.7	9.1	5.5	3.8	2.8	34.7	10.0	6.6	4.3	55.6	11.3	5.8	4.2	2.7

TABLE 12. RATES OF MORTALITY * AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DURING SPECIFIED PERIODS AFTER ADMISSION

(Classified According to Age at First Admission)

Age at First Admission (Years)	Males									Females								
	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year
Under 15	38.9	.....	.....	10.2	12.2	4.2	16.9	15.4	.....	19.4	41.2	.....	21.6	19.3	.....	.....	28.6	.....
15–19 ...	31.0	18.8	4.0	4.1	13.7	7.4	13.4	15.8	17.7	32.8	7.9	.....	.....	10.1	7.3	13.2	7.9	.....
20–24 ...	62.3	8.7	12.1	6.3	21.4	11.6	10.9	.....	13.1	76.5	11.9	7.4	10.1	25.7	6.9	20.1	10.6	21.7
25–29 ...	71.4	23.3	27.6	9.4	30.4	13.0	13.4	6.5	23.5	47.8	17.8	10.2	14.7	21.6	12.0	17.8	12.2	18.7
30–34 ...	83.9	35.1	25.3	26.0	39.0	7.9	15.9	39.1	28.0	93.4	31.2	15.2	9.7	35.8	9.4	26.9	35.6	26.9
35–39 ...	219.6	92.0	38.8	17.1	84.3	29.5	38.0	16.8	21.1	116.8	43.8	28.2	11.5	47.7	15.5	14.8	18.1	8.0
40–44 ...	291.1	70.8	44.6	37.7	102.1	41.7	52.3	43.4	22.1	209.2	28.4	26.9	29.4	70.0	26.8	26.0	15.2	26.1
45–49 ...	364.4	135.7	88.1	82.8	150.8	57.7	34.2	32.3	.....	276.6	73.4	61.2	47.7	108.3	27.5	27.8	42.8	32.7
50–54 ...	514.4	191.8	126.6	76.0	203.7	68.6	86.1	53.8	66.7	376.4	115.8	69.1	73.4	147.4	52.3	42.6	68.6	45.4
55–59 ...	667.5	243.9	188.8	131.6	270.0	85.0	87.3	84.7	104.6	576.2	144.8	123.6	126.4	220.8	86.3	88.2	55.1	84.5
60–64 ...	886.8	326.9	235.6	211.8	356.2	148.2	147.9	147.7	88.4	838.7	264.7	193.4	164.4	321.5	110.5	129.8	78.2	110.6
65–69 ...	(1000.0)	390.8	320.2	254.1	439.8	195.3	197.3	169.6	195.1	903.0	406.2	251.4	229.2	398.8	182.3	157.2	139.4	132.6
70 or over...	(1000.0)	696.7	506.2	457.7	627.7	288.9	280.6	290.7	332.1	(1000.0)	636.0	502.2	376.2	654.7	295.3	248.7	250.4	213.6

* Per 1,000 annual exposures.

† On an annual basis.

Females showed the same trend. During the first three months the death rates grew from 19.4 among those less than 15 years of age at time of admission to 993.0 at ages 65 to 69. If continued throughout the first year, the death rate among those admitted at age 70 or over would have been 100 percent. However, the rates decreased rapidly after the first period of hospitalization of three months, the average for the first year being considerably lower. The average rate for the first year decreased from less than 20 per 1,000 among those admitted at ages under 20 to almost 600 for those admitted at 70 or over. During the second year of hospitalization, the rates increased with advancing age at first admission from seven to almost 300 per 1,000.

Attention should be directed to the important fact that after the second year of hospitalization the death rates were stabilized at a very low level.

The relation between the duration of the mental illness before hospitalization and subsequent mortality is not as clear-cut as that shown with respect to age. This may be due to the difficulties of estimating exact durations, when symptoms have developed over many years. Nevertheless, it appears that the average mortality after hospitalization is lower among those with short previous histories and higher among those with long histories. The relation may be due, in part, to the fact that those with long histories of disease are also likely to be older.

Table 13 shows the percentage of deaths occurring during specified periods of hospitalization in relation to the duration of the mental disease before hospitalization. During the first year, the percentage of patients dying increased among males from approximately 25 percent among those with short previous histories to over 30 percent among those with long histories. During the second year, the percentage grew from an average of about four percent among those with short prior durations to almost six percent among those with longer prior durations. This trend was even more marked among females.

Table 14 gives the rates of mortality per 1,000 annual exposures. That these rates vary directly with the duration of the mental disease prior to hospitalization is evident. During the first year of hospitalization, the rate grew among males

TABLE 13. PERCENT OF FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DYING DURING SPECIFIED PERIODS AFTER ADMISSION
(Classified According to Duration of Mental Disease Before Admission)

Duration of Mental Disease before Admission	*Males*									*Females*								
	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	2nd year	3rd year	4th year	5th year	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	2nd year	3rd year	4th year	5th year
Less than one month	15.4	3.4	2.0	1.6	22.4	3.4	1.9	1.2	1.4	11.6	1.9	1.8	1.3	16.6	2.5	2.2	1.2	0.6
1– 3 months.	17.2	3.9	2.4	1.8	25.3	4.2	2.7	2.3	1.8	13.6	3.0	2.0	1.3	20.0	3.1	1.6	1.4	1.3
4– 6 months.	17.9	4.3	2.4	1.8	26.4	5.6	2.8	1.9	0.4	12.0	4.3	2.2	1.7	20.2	4.5	1.9	1.6	1.3
7–11 months.	14.1	5.1	1.9	1.4	22.5	5.6	3.0	1.9	2.2	13.6	4.1	2.3	1.8	21.7	4.5	2.3	2.1	1.3
1 year	20.4	5.3	3.2	2.0	31.0	5.6	2.4	2.4	1.4	15.4	5.0	3.4	2.4	26.4	6.4	3.3	2.4	1.4
2 years	20.8	6.2	4.6	3.4	34.9	5.1	5.0	1.8	1.3	18.4	6.1	3.3	2.8	30.7	7.2	3.6	2.9	1.8
3 years	21.1	4.4	3.0	2.8	31.3	5.1	4.2	1.4	...	17.8	5.8	3.8	2.4	29.9	8.0	4.8	3.1	1.1
4 years	19.0	7.0	4.6	1.7	32.3	4.4	3.0	2.1	...	17.2	5.8	4.4	2.4	29.8	8.2	4.3	4.1	3.0
5 years or over	18.4	4.4	3.2	2.5	28.6	5.3	2.7	1.9	1.9	15.0	4.6	3.7	2.9	26.1	6.8	3.8	3.0	3.1

TABLE 14. RATES OF MORTALITY * AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DURING SPECIFIED PERIODS AFTER ADMISSION

(Classified According to Duration of Mental Disease Before Admission)

Duration of Mental Disease before Admission	*Males*									*Females*								
	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year
Less than one month ...	727.6	207.2	131.4	112.8	251.9	85.9	92.3	79.1	99.6	474.4	100.6	98.0	73.9	179.0	52.3	95.0	73.1	43.7
1– 3 months	745.4	215.4	140.4	114.4	270.3	88.6	100.8	111.4	100.2	582.3	156.9	112.7	76.5	212.5	64.1	62.5	70.4	73.0
4– 6 months	777.6	242.0	145.9	115.8	283.1	119.9	109.3	92.2	20.5	517.9	223.7	124.2	99.5	216.4	90.7	72.1	74.6	69.8
7–11 months	619.8	285.0	117.2	94.9	248.0	117.5	100.0	78.8	114.9	581.3	214.3	131.2	104.3	232.0	90.4	81.0	93.5	65.6
1 year	874.5	302.3	200.6	136.9	329.6	121.8	126.7	122.1	82.8	652.1	261.4	191.3	148.5	277.0	120.2	99.6	86.8	58.8
2 years.....	882.4	354.0	293.4	237.0	370.8	120.0	182.5	90.2	74.1	771.4	327.2	194.8	173.1	319.7	138.8	108.4	103.4	74.1
3 years.....	902.2	259.2	191.3	189.8	335.0	111.1	134.1	62.1	....	743.1	307.3	222.5	153.2	312.1	149.9	137.4	118.1	108.7
4 years.....	801.6	391.1	290.3	114.1	342.1	99.2	109.1	96.4	....	711.6	299.9	245.4	146.6	309.0	146.5	114.0	132.0	116.3
5 years or over	794.4	250.4	194.9	166.8	306.4	107.2	78.9	68.2	75.7	623.9	232.3	197.4	163.4	270.0	115.4	89.5	80.9	92.2

* Per 1,000 annual exposures.

† On an annual basis.

from 251.9 among those with a very short history to over 300 among those with long histories. Among females, they varied during the first year of hospitalization from approximately 200 to over 300 in relation to the prior duration of the disease. As the periods of hospitalization grew to more than two years, the rates of mortality grew smaller and smaller, and tended to stabilize themselves, so that shorter or longer histories of prior mental illness did not affect significantly the size of the subsequent death rates.

The processes of discharge and death result in residues of patients at the end of specified periods of hospitalization. The percentage of such patients remaining continuously on

TABLE 15. PERCENT OF FIRST ADMISSIONS REMAINING IN CONTINUOUS RESIDENCE AT END OF SPECIFIED PERIODS AFTER ADMISSION

Period	*Males*	*Females*
End of third month	72.4	77.9
End of sixth month	65.4	71.7
End of ninth month	61.3	67.9
End of first year	58.1	65.0
End of second year	30.6	32.8
End of third year	23.1	25.3
End of fourth year	18.8	21.4
End of fifth year	16.4	19.4

the books at each specified period is shown in Table 15. As with discharges and deaths, it was necessary to adjust for the fact that the cohorts were exposed for varying periods. The first cohort, that for 1943–1944, was followed for a period of five years. Succeeding cohorts were exposed for lesser periods, ending with only one year for the cohort of 1947–1948. In consequence, the percentage at the end of the fifth year after first admission could be derived only from the experience of the cohort of 1943–1944. From this and the succeeding cohort, it was possible to obtain an average percentage of those remaining at the close of the fourth year. This was continued backward until all five cohorts were included in the experience of the first year after hospitalization. Thus, the percentages on the books after continuous residences of three, six, nine, and twelve months are based upon the experience of all five cohorts.

It appears that within three months, the average percentage of males remaining continuously on the books was 72.4. The

rapid reduction during this period was due to the fact that discharges and deaths were both numerous during this period. At the end of the first year, 58.1 percent of the males were still on the books. Thus, whereas 27.6 percent of the males were removed from the books during the first three months, only 14.3 percent were removed during the next nine months. At the end of the second year of hospitalization, 30.6 percent of the males were still on the books. This rapid increase of removals during the second year resulted primarily from the termination of placements in convalescent care, most of these placements having occurred during the previous year. After the second year, discharges were relatively few, but mortality increased. In consequence, the percentage of male patients remaining on the books was only 16.4 at the end of the fifth year.

Females were removed from the books at a slower rate than males throughout the entire period. Thus, 77.9 percent were on the books at the end of three months, compared with 72.4 percent of the males. At the end of the first year, the percentages were 65.0 and 58.1 for females and males, respectively. The disparity was reduced by the end of the second year, the percentages having become 32.8 and 30.6 for females and males, respectively. This was due to the greater rate of discharge for females during this period. Finally, at the close of the fifth year, the percentage of females on the books was 19.4, compared to 16.4 for the males.

The greater hospital life of females may be emphasized by the fact that the median duration for females was 17.6 months, compared to 15.5 months for males.

The preceding data refer to patients on the books after periods of continuous residence in the hospitals. If, however, we include patients who were readmitted after discharge from the books it then appears that 20.3 percent of the male cohort were on the books at the end of five years, compared with 23.1 percent of a male cohort admitted during 1909–1910.[6] For females, the corresponding percentages were 24.4 and 28.5. The primary reason for the difference lies in the greater mortality of the current cohorts, arising from the increased admissions of patients with senile and arteriosclerotic mental disorders.

We now have a summary description of what happens to first admissions to the New York civil state hospitals within a period of five years after admission. To obtain the results, we combined and arranged the data for five successive cohorts of first admissions. Included in these cohorts were those first admissions who had spent the complete interval between admission and discharge from the books within the state hospital system. The first cohort was admitted during the fiscal year ending March 31, 1944, and each member of the cohort was followed for a maximum period of five years from date of admission. Since the closing date of the period of observation was March 31, 1949, the members of successive cohorts were under observation for a year less than each preceding cohort. Thus, the members of the fifth cohort, consisting of first admissions during the fiscal year 1947–1948, were followed for only a year from date of admission. Percentages and rates of discharge and death were derived from successive intervals after first admission, and in each case they were based upon the members who were exposed to risk during such intervals.

On the basis of average percentages of annual discharges, 42.0 percent of the male first admissions were discharged from the books within five years after admission. The most rapid period of discharge was the first three months after admission. During this period, the rate of discharge was 453.4 per 1,000 annual exposures. The rate dropped rapidly during the remainder of the first year, and averaged only 166.5 for that period. The rate rose to 395.4 per 1,000 during the second year, and then decreased to 36.4 per 1,000 during the fifth year. The rate of discharge was high during the second year, because of the culmination of periods of placement in convalescent care, about 80 percent of which had begun during the first year. It follows, therefore that approximately 30 percent of the male first admissions had left the hospitals within one year, either by direct discharge from the hospital or by placement in convalescent care.

The trend for females was similar to that for males, but the discharge rates were at a lower level, especially during the first year. As in the case of the males, it may be estimated that approximately 30 percent left the hospitals during the

first year, either by discharge or by placement in convalescent care.

There was a marked inverse relation between the rate of discharge and the age at first admission. The older the groups at admission, the lower the rates of discharge. A similar inverse relation, though not so marked, existed with respect to the estimated duration of the mental disease before admission to the hospital. The longer the prior duration, the lower the rate of discharge.

As with rates of discharge, the first three months after admission were also crucial with respect to mortality. Thus, 18 percent of the male first admissions died during this period, compared with an average of 27.4 percent for the entire first year. During the first three months, patients died at the rate of 786.1 per 1,000 annual exposures. The death rate dropped very rapidly after this period, and continued to decrease to a minimum rate of 88.6 during the fifth year.

The trend was the same for females, though in each period of hospitalization the rate for females was less than that for males.

There was a marked direct relation between rates of mortality and age at first admission. The rates increased steadily with advancing age at hospitalization. There was a positive but low degree of correlation between rates of mortality after hospitalization and the duration of the mental illness before hospitalization. This may be due, however, to the fact that those with long prior histories of disease may also be older at time of hospitalization.

As a consequence of discharges and deaths, the number of first admissions remaining continuously on the books after hospitalization decreased steadily. Among males, the average percentage at the end of three months was 72.4. This dropped to 58.1 percent at the close of the first year, and to 30.6 percent at the close of the second year. After this year, discharges and deaths were both reduced significantly, resulting in a low rate of further decrease among the patients, who then constituted a chronic group. At the end of the fifth year, 16.4 percent were still on the books. At this period of hospital life, the percentage on the books is, for practical purposes, equal to the percentage actually in residence.

Primarily as a result of lower death rates, the percentages of females remaining on the books at the close of specified periods exceeded the corresponding percentages for males. At the end of the crucial period of three months following admission, 77.9 percent of the female cohorts were still on the books. This decreased to 65.0 percent at the end of the first year, to 32.8 percent at the end of the second year, to 19.4 percent at the end of the fifth year.

The median durations of hospital life from admission to discharge from the books were 17.6 months for females, and 15.4 months for males.

These rates of discharge and death, and consequently the percentages of patients in continuous residence at the close of stated periods, are averages for the cohorts of first admissions. Whether rates be high or low depends primarily upon the types of patients entering into the cohorts. Patients with psychoses of advanced age constitute a different order of risk from other groups of patients who enter the mental hospitals at considerably younger ages. Succeeding parts of this investigation will, therefore, treat separately the "natural history of hospital life" of cohorts consisting of members of the seven largest groups of first admissions to the New York civil state hospitals.

REFERENCES

1. "Expectation of Hospital Life and Outcome for Mental Patients on First Admission," by Raymond G. Fuller. *Psychiatric Quarterly*, Vol. 4, No. 2, April 1930, p.312.

2. Rates of discharge computed from data in reference 1, p.312.

3. Computed from data in "Hospital Departures and Readmissions Among Mental Patients During the Fifteen Years Following First Admissions," by Raymond G. Fuller. *Psychiatric Quarterly*, Vol. 4, No. 4, October 1930, p.659.

4. See reference 1, p.306.

5. Rates of mortality computed from data in reference 1, p.306.

6. See reference 1, p.301.

BOOK REVIEWS

MENTAL HEALTH PLANNING FOR SOCIAL ACTION. By George S. Stevenson, M.D., Sc.D. New York, McGraw-Hill Book Company, 1956. pp. ix + 358.

Many a mental health association begins its career as an enthusiastic core of dedicated people who are humanitarian in their attitude and are convinced that lay citizens have a great deal to contribute to problems of mental health and the treatment of the mental illnesses. Unfortunately, since much of the initial planning is done on the basis that it is good to discuss matters in groups and that these discussions will of themselves produce tangible results, all too often the organization finds itself "all dressed up with no place to go." The inevitable result is frustration on the part of the members, inability to extend the influence of the organization, and a great deal of wasted energy.

From any point of view this sequence of events is regrettable. In this particular field it is tragic, for it is certainly obvious by now that the problems of the mental illnesses cannot be solved by waiting for fairy godmothers in the research laboratories to come up with panaceas or by hoping that in some mysterious way greater numbers of trained personnel can be produced. An interested and really effective total social approach is the one which offers most possibility in the light of our present knowledge of the field. We cannot afford to waste this potential source of power in unproductive community meetings, however lofty the aims of those well-meaning groups.

In this situation this book provides from the broad background of the author a document as practical as a road map. The traveler in the uncharted areas of community participation can, in these pages, find constant reference points with which he can check his progress and plan his further trips. Dr. Stevenson is able to offer not only a great mass of factual material but also to make of this foundation a springboard for flights into far-reaching suggested plans which mental health organizations can and should carry out.

The book is divided into sections. Part One deals with an overall perspective of the problem with specific notes on program planning and criteria by which on-going and proposed programs can be constantly evaluated and re-evaluated. Part Two has 14 chapters on the various aspects of the mental illnesses with a great deal of useful information on the general care of the mentally ill as well as on the problems of the mentally deficient, narcotic addiction, the Veterans Administration program, and the legal aspects of the various problems of follow-up care and rehabilitation. Part Three deals with the general problem of prevention, Part Four with mental health in its rela-

tion to the various aspects of society, and Part Five with a down-to-earth discussion of mental health organizations including the problem of world mental health. A very practical appendix contains a categorized list of available visual aids.

Interspersed with these descriptions of existing facilities and suggestions as to various types of practical programs, the author has placed some of his own progressive ideas regarding possible ways of improving the *status quo*. He mentions such matters as the augmentation of the general hospital care of psychiatric patients, the usefulness of agencies not formally labeled as "psychiatric" but providing invaluable service nonetheless, the dangers inherent in professional isolation, and the advantages of decentralization of hospitals. Some readers will dislike these ideas, for they will not suit the psychiatrist who lacks a sense of community responsibility, the state hospital superintendent who defines expansion in terms of increasing his own isolated empire, and the social agencies which prefer to exist in a vacuum. It may be that mental health associations will find professional workers in their communities who will subtly but definitely resist the broad planning necessary for a concerted attack; Dr. Stevenson has provided here sufficent ammunition to make complacency uncomfortable.

The book should have many uses. Perhaps one which fits in with the author's general intent would be as a textbook for a workshop involving interested citizens with discussion groups to elaborate on the material contained in these pages. It seems almost inevitable that such an arrangement would result in a period of new growth and revitalized productive activity in almost any organization dealing with the problem of the mental illnesses.

C. H. Hardin Branch, M.D.

University of Utah

Children in Play Therapy; A Key to Understanding Normal and Disturbed Emotions. By Clark E. Moustakas. New York, McGraw-Hill Book Company, 1953. 218 p.

This volume on the nature and value of play therapy in the adjustment of both normal and disturbed children is written primarily for parents and teachers. Dr. Moustakas follows the techniques of "non-directive therapy" as developed by Carl Rogers and as applied, specifically, to children by Virginia Axline. The Rogerian method emphasizes a permissive approach "which allows the individual to articulate with growing confidence what he thinks and feels."

When the author states that "the three basic attitudes in child-centered play therapy are faith, acceptance, and respect," he is voicing not only the attitude to be employed by a non-directive therapist, but what should also be the approach of an understanding teacher or

parent. Unfortunately, however, few teachers have classes small enough to enable them to carry out this approach, even when they are capable of doing so.

This reviewer agrees with Dr. Moustakas that no attempt should be made in play therapy to interpret to the child the symbolism involved in his play, but rather that the child should be encouraged to express what the play means to him.

Dr. Moustakas expresses positive faith in the children's potentialities in his "belief that children have within themselves capacity for self-growth and self-realization." He illustrates this approach by transcriptions of tape recordings of actual play therapy episodes. In these recordings, examples are offered of the way in which children work out their hostilities against their parents, and their jealousy at the birth of a brother or sister; one long study illustrates how parents as well as child were helped to work through their emotional difficulties.

In the report on "Play Therapy with a Pre-School Family" the child described showed evidence of a severe phobic condition. The report tells of marked improvement in overcoming obsessive-compulsive behavior and a disappearance of fears during play therapy sessions, as well as an easing of the parents' pressures on this only child, which, according to the therapist, "helped Kathy to achieve more positive attitudes toward herself and others and to be more emotionally comfortable." Although this child was temporarily relieved of fears and tensions, her unresolved anxieties might later need more intensive treatment than was offered by such non-directive therapy. The question remains open, therefore, whether the permissive and sympathetic response of the Rogerian therapist can resolve severe unconscious conflicts.

The author reports on the way some children in play therapy sessions are interested in undressing both boy and girl dolls. But the Rogerian technique of affirming or repeating the child's own words may not uncover the child's unverbalized questions about birth and sex, nor will it necessarily reveal a child's unconscious symbolic responses.

While some of the recorded play sessions show positive therapeutic results, a doubt remains as to the final consequence of such treatment in more severe cases. Will it be enough for some of these children to express to the therapist their hostility against a parent? Or will regression to an infantile state be enough to release emotional difficulties in a lasting way? Or will entering into a fantasy world in a few play therapy sessions be sufficient to help the child make a satisfactory adjustment to reality?

Dr. Moustakas explains that as children play out their attitudes of

hostility, anxiety, and regression in his presence, such emotions will be released and transformed into more positive feelings. This may happen frequently with mildly disturbed children, but this may not be the inevitable conclusion (as stated by Dr. Moustakas) that "the child's emotional problems and symptoms are reflections of his attitudes, and as the attitudes change the problems and symptoms disappear." For in many cases an emotionally disturbed child's attitudes are defensive responses to mishandling by one or both parents. If the parents are not dealt with directly, when such a child is severely disturbed, a permanent recovery may not be possible.

Dr. Moustakas, a staff member of the psychology and mental hygiene department at the Merrill-Palmer School in Detroit, has had an unusual opportunity to orient parents as well as teachers to the value of play therapy in working through the emotional problems of young children. He seems over-optimistic, however, in his claim that "most parents seem to accept the fact that emotional frustrations and disturbances in children are frequently motivated by an impairment in family relationships which often is rooted in early family experiences. They understand that a troubled child may have a history of experiences where he was made to feel incapable, insecure, and inadequate, and that these feelings of worthlessness often pervade everything the child does and prevent him from functioning effectively. Many parents accept the idea that feelings of inferiority may arouse anger and guilt and fear, and that the more severe the child's sense of personal unworthiness and rejection, the more likely is he to have deep underlying feelings of anxiety and hostility."

Dr. Moustakas' comments on the readiness of parents to understand the cause of a child's anxiety and hostility is contrary to the experience of many therapists. Since a small child's emotional disturbances are, to a large extent, due to mishandling by parents, such parents are more likely to blame a child for his emotional unbalance than to accept their own role in causing such disturbances.

To illustrate how one mother was able to immediately benefit from one of his talks to parents, Dr. Moustakas cites a Mrs. A. In a personal interview following this lecture, the author had advised this woman "to listen to (her daughter) Betty's feelings, accept them, and indicate that she understood them." The mother ran into some resistance in getting her daughter to talk about her own feelings; this then made the mother decide to talk to her own parents about her own long repressed feelings.

> "I took them (the parents) into the kitchen and closed all the doors and told them to sit down. I think it was the hardest thing I ever did. They looked at me in a puzzled way and wondered what in the world it was all about. After two minutes silence while I was struggling to hold onto myself, I finally said the words: 'I want you to know that there were

> many times in my life when I hated you both. I couldn't say it then, but you said many things to me and did many things to me that really hurt me, and I hated you for it.' ''

This woman then heard from her parents, for the first time, how they had also hated her. After each had admitted such feelings, the mother and her parents cried together, and she concludes, ''We knew that we really loved each other.'' In writing this to Dr. Moustakas, she added, ''You don't know how wonderful that made me feel. . . . I seemed to be a different person. I began to see many attitudes in Betty that I never knew existed.''

Excerpts from this case have been quoted, since Dr. Moustakas considers it an example of the successful application of his child-centered philosophy. To this reviewer, however, it shows, rather, the limitations of the Rogerian technique. For to assume that a single episode, in which a lifetime of repressed hostility was expressed by this mother against her own parents, would be able to transform her entire relation, first to her parents and then to her child, is just a little too simple to be convincing.

Dr. Moustakas has wisely emphasized that his approach is ''not mainly concerned with techniques and skills but rather with the kind of relationship which enables children to grow emotionally and to gain faith in themselves as feeling individuals.'' Playing out their problems in the permissive and accepting environment which the author describes may work well with normal and slightly disturbed nursery school children but rarely with those who are more severely disturbed.

New York City MARGARET NAUMBURG

THE GROWING FAMILY, A GUIDE FOR PARENTS. Edited by Maxwell S. Stewart. New York, Harper and Brothers, 1955. 264 p.

This book is made up of ten popular pamphlets published by the Public Affairs Committee. Each pamphlet was designed for a particular public, and apparently it is the thought of the publishers that they now have a sequence of these pamphlets and can put them together in book form and thus have a useful tool. The result is a fairly successful try, but there are some hurdles in such an attempt.

The style in pamphlet writing is to hurry and get it said because one has only 48 pages! The style in book writing is more leisurely. An author does not hesitate to take time for examples and illustrations and thus rest the reader. In the present volume the pace never lets up. Everything is generalized. There is little time for the specific instance.

By and large, as this reviewer knows the literature, the material seems accurate, and it is well written. There is only an occasional

statement which is inaccurate or a conclusion which seems reached too hastily. A good analogy is that of riding in an airliner. You go along smoothly and all of a sudden you hit a bump in the air. The plane straightens out after a moment and soon you forget there was ever any roughness, and it was never very important.

There is some satisfaction in seeing several writers adopt very much the same point of view. In fact, in reading this material one finds that we are arriving at a sort of an eclectic approach to child care and training. The writers of this material are from different professional backgrounds, and yet they seem to approach their assignments with very similar principles and methods.

The book is made up of chapters geared to ages—infancy, early childhood, later childhood, adolescence. And then certain special topics are introduced—sex education, discipline, entertainment, and family living. It is a good arrangement, but one wonders whether a wiser plan might have been to continue the chronological sequence and have chapters on the college-vocational training age, entry into the world of work, maturity, and the period of decline.

I am sure the editor has done an excellent job of deleting and relating the materials, although this reviewer did not go back and make comparisons, paragraph by paragraph, with the original pamphlets. In spite of good editing, however, the amount of duplication of topics is considerable, and is so integrated into the material that no editor could eliminate it. However, this may not be a bad thing because we know that repetition usually enhances learning.

One wonders for whom the book was designed. It is not a text; it is not a reference book. It was not planned for parents of children of a particular age group. We feel it is especially suitable for study groups and "program" people. It will be helpful to those who are endeavoring to get a picture of child development from the pre-natal through the adolescent period, with the emphasis on young children. It would seem especially useful for discussion groups.

Great differences in style of writing occur, and this gives a certain charm to the book.

LOYD ROWLAND

Louisiana Society for Mental Health

NEW DIRECTIONS IN SOCIAL WORK. Edited by Cora Kasius. New York, Harper and Brothers, 1954. 258 p.

This volume was compiled as a tribute, by fourteen of his colleagues, to Philip Klein, "social worker, educator, and scholar" who throughout his career has given direction to the development of the theory and practice of social work. The various articles by outstanding educators, administrators, and thinkers in the field identify the significant

aspects of a profession still in the process of defining itself, but at a point of maturity where it can critically examine and question what it is doing and why.

Almost at the beginning a leader in the field asks, without providing the answer, "What is social work?" Throughout there is a reaching out for a specialized body of knowledge, principles, and concepts that are peculiar to this field, that distinguish it from the social sciences, psychiatry, and other fields from which much of its knowledge and skills stem. The need of formulations that are validly derived from experience and practice is reiterated. The writers are preoccupied with the evolving character of what should be transmitted in professional education or of what can be applied to social problems in other countries. Some of the myths, assumptions, and contradictions that color practice are subjected to an overhauling that is no less trenchant because of its wit.

Nonetheless, an underpinning of basic conviction emerges from this appraisal of changing, sometimes uncertain or ineffective efforts to help people. Social work does have a specific area of competence in providing services to help people with social problems. It has grown out of a belief that each individual can and should have a good life. It shares with other fields concern about people and their well-being, but it has particularly taken on the task of seeing to it that the needs of individuals are being adequately met. It has acted on what it has learned from working with people: what they are like, what they need, and what happens when they lack. It has considered the individual as a whole and in relation to his family, to his social group, and to an environment which may fail to provide what he needs to do those things that are expected of him. It deals with social problems that result from failures and inadequacies in meeting the individual's needs through the usual provisions or existing social institutions for doing so. It recognizes a multiplicity of causes that may lie both in the deficiencies of the provisions and in some incapacitation of the individual for using them.

The writers discuss the remedies provided by social work that have ranged from pioneer reform movements to correct, modify, or supplement the social environment or social institutions to techniques for the treatment and "adjustment" of the individual to his circumstances (sometimes referred to as "a less expensive form of psychiatry"). They point up the responsibiilty which has been increasingly assumed by government in its role of promoting the general welfare through social insurance and public assistance programs. The problems of financing both public and voluntary services are related to the low priority given to human needs and to lack of understanding of the value of social services that are preventive and rehabilitative.

Little attention is given to the professional skills which have been developed to help individuals through case work or group work methods and which are the main subject of current professional social work literature; but the obligation to interpret social needs, to participate in social action and community organization is underscored.

The new direction for social work is suggested: one that will lead the field to its own place and particular competence, in relation to other disciplines, where it can help in bringing about those conditions that make it possible for each person to have a better life, and can enable those individuals who by themselves cannot do so to develop, use, and enjoy their potentialities. The serious student will find the guideposts in this scholarly analysis of the objectives, methodology, and achievements of the field.

ZITHA R. TURITZ

Child Welfare League of America

MENTAL HEALTH AND MENTAL DISORDER: A SOCIOLOGICAL APPROACH. Edited by Arnold M. Rose. New York, W. W. Norton, 1955. 626 p.

The Society for the Study of Social Problems seeks to "stimulate the application of scientific method and theory to the study of vital social problems, encourage problem-centered social research, and foster cooperative relations among persons and organizations engaged in the application of scientific sociological findings to the formulation of social policies." The society holds an annual meeting at the time of the American Sociological Society conference in September and a second meeting in February with the Society for the Psychological Study of Social Issues, an affiliate of the American Psychological Association.

When the Society for the Study of Social Problems came into being in 1951, the new organization selected Dr. Arnold M. Rose of the University of Minnesota as the first chairman of its editorial and publications committee. The plans for this book were laid at that time.

The appearance of the volume symbolizes the growing interest of sociologists, social psychologists, and social anthropologists in studying problems related to mental health and mental disorder. It also reflects the growing awareness on the part of psychiatrists and psychologists that the cultural and interpersonal factors are an important part of any analysis of causation, prevention, or rehabilitation. In fact, it signals the rapid coming of age of the new field, "social psychiatry."

Concerning the impressive array of contributors, the editor says, "While most of the authors have had their primary training as

sociologists, several are psychiatrists, psychologists, and anthropologists. In this truly interdisciplinary field, the formal educational background of an investigator is of less importance than the scope and quality of his contribution. To further this point of view we shall not make invidious distinctions by labeling our authors as to discipline or by designating them as having the degree of Ph.D., M.D., or M.S." (Preface, xiii and xiv) One-fourth of the selections are published for the first time in this volume. The others have been taken from various sources.

Appropriately, the volume is dedicated to Ernest W. Burgess, first president of the Society for the Study of Social Problems and himself a long-time student of social factors in personality development and in problems of the family.

Section I of *Mental Health and Mental Disorder* gives Dr. Burgess and three other authors an opportunity to define "problems of social psychiatry" and to state their general views in what the editor calls a "theoretical overview." Succeeding sections are concerned with social characteristics of the mentally disordered, the community setting, and social aspects of specific disorders, and concludes with three sections which cover a variety of marginal problems ranging from alcoholism to public attitudes toward mental illness and "mental hygiene and the class structure."

As is true of most symposia the volume dips into many fields. To some readers this will be confusing. After touching for only thirteen pages on such a complicated topic as "Social Stratification and Psychic Disorders" the book shifts rapidly to a brief look at occupation as it relates to mental disorders and ethnic variations. These brief glimpses do, however, introduce the new student of mental hygiene and also the narrowly specialized scholar to the present leaders in the broad field of social psychiatry, to the concepts and research methods they use, and to the trend of their findings.

The essays are irregular, not in quality but in type. Some are brilliant, general statements of trends and theories. Other chapters include detailed reports of studies dwelling upon such questions as whether persons who sleep with their mothers during infancy are more or less likely to develop personality difficulties later on, suicide rates in rural Michigan, and "becoming a marihuana user." The reader must choose for himself which essays introduce him best to the field. He can be certain that the volume gives him a nodding acquaintance with the principal research approaches and the most authoritative spokemen of them.

The volume is carefully edited, well-printed, and the documentation refers the reader to the larger studies.

ROBERT L. SUTHERLAND

Hogg Foundation for Mental Hygiene

TRUANTS FROM LIFE. By Bruno Bettelheim. Glencoe, Ill., Free Press, 1955. 511 p.

This book is a classic in the ever-widening field of institutional treatment of the disturbed child. It gives to the profession the very essence of the Orthogenic School. The description and documentation of almost superhuman effort in helping a generally untreatable group of children is as forthright an account of success and failure as the literature on this subject has offered since *Wayward Youth*. This is practical, on-the-job research at its most sophisticated level, a work from which practitioners in the field can draw endlessly and each time find the threshold of renewed effort and inspiration.

In its quest to explore the limits of institutional treatment the school selects the very sick child, the one where all other efforts and therapies have failed. That its methods have led to rather phenomenal success in many of its children should not, however, lead others to blind assumptions or foolhardy imitation.

There has, in fact, been far too much of the panacea-type development in this field and the book should provide a sobering outlook to those who seek similar gains but are not prepared to invest the necessary measure of funds and human energy. The four remarkably detailed and live case histories set the highest standard of scientific inquiry and personal demand upon those workers who under Bruno Bettelheim dedicated themselves to these children. Having read this book one gains a new perspective and caution regarding the so-called "successful treatment" of the disturbed child. It establishes the fact dramatically that for such severely disorganized children there is no shortcut back to the world of reality and useful social living.

It should help many institutions who are working with the less seriously disturbed child to evaluate the effectiveness of their own programs and personnel. One can see how many well-intentioned programs with insufficient resources can be just short of the critical strength needed, and may therefore be entirely wasted or do more harm than good.

By implication, the case histories of these children reinforce our conviction of the need for earlier and more comprehensive diagnosis. Many of the children at the Orthogenic School are the residue of previous agency failures, a point on which the author is rather gracious in his discussion. Cases which had been known to a variety of agencies for a period of several years prior to admission to the school lead inevitably to the conclusion that a complete family diagnosis of sufficient scope had never been made. For in unraveling the child's early life one can see that a better analysis of the total family situation would have led to a more inclusive treatment plan and more accurate differential diagnosis of both parents and children.

It is a common failure of our highly specialized services to families and children that they lack the skills and perspective for total diagnosis, that treatment is often individual and symptom-centered. When the child can finally no longer be tolerated in a normal environment, his only resource for help may be the institution. Could this have been prevented by those agencies and therapists who first knew the child, and should have known the total family, several years earlier? Can we so organize our specialized skills and agencies to synthesize our efforts more effectively for an earlier arrest of such problems? These are important questions to which this book does not address itself, for this was not its purpose. But for many who read it there cannot be satisfaction alone in the good job done at this late and costly stage.

The reality of the matter is that the Orthogenic School's investment begins at the end of personal disaster. In addition to the benefits gained by a few children, the school's greatest contribution may well be its illumination of the total life complex which harbors the seeds of mental illness. Can we learn from these histories and the many evidences of early family disorganization how to deal with reactions and interactions in the family constellation more successfully? For as long as we are not equipped to do so and children continue to move from one agency to another as problems become more severe, we will need a service of last resort. In a very practical way we know that there can never be enough orthogenic schools to meet the need. The majority of such children will continue to flow into hospitals and correctional institutions. Also these children might have been helped with a lesser per capita investment earlier, and available resources spread to serve more children.

This book, then, makes two major contributions to the field: first, it is an unusually fine account of the creative treatment of severely disturbed children; second (though not expressly so intended by the author), the book poses a basic challenge to all agencies in the adjustment field to examine the effectiveness of their methods, the incompleteness of too highly specialized effort, and the possible development of an earlier, more comprehensive attack upon the evidence of interrelated factors in family breakdown.

FRANK T. GREVING

New York City

CULTURE AND MENTAL DISORDERS. By Joseph W. Eaton and Robert J. Weil. Glencoe, Ill., Free Press, 1955. 254 p.

This fine book studies the Hutterites, members of an intriguing religious sect who live in the American-Canadian West and carry

on an Anabaptist and economically communal tradition more than four centuries old. They live in small self-contained farm colonies. These colonies are noncompetitive, oriented toward stability and social order, providing every member with a high level of economic security from birth to death.

This work shows very clearly how in these people the adaptation problems which constitute what we call normal and abnormal behavior are very much mitigated, leading to a great reduction of emotional and mental disorders. This group is like a small laboratory, where the psychologist, the psychiatrist, and the anthropologist are able to study experimentally man living in a quite different setting than that of modern western civilization.

The conclusions are definite, concerning the great influence of culture in producing and shaping man's behavior, either in the form we call normal or in the one we call abnormal. It also shows how important it is for psychiatry to integrate in its body of knowledge sociology and the study of interpersonal relations. On the other hand, it shows how no culture can provide immunity from mental disorders. We also conclude that man needs to be in close contact with his fellow-men in order to live a happy and productive life. It is equally paramount to have an ideal, religious or any other kind.

In many ways the book leads to conclusions quite similar to those of Erich Fromm, a "cultural psychoanalist," who demonstrated that man from the Middle Ages to modern times, while trying to find his freedom, often becomes bewildered and anxious to the point of choosing to submit himself unconditionally to dictatorial governments.

The analyses of psychoses among the Hutterites brings support to the idea of the need to review the Kraepelin conception, which still exists in psychiatry. For instance, it seems that depressive and manic states among the Hutterites are never alternated, and this speaks against what the authors call the "forced marriage" between both states in the so-called "manic-depressive psychoses." Actually, the authors' observations indicate that many depressive states should be considered apart from that syndrome.

Regarding schizophrenia, their conclusion seems to be that sociological factors have only limited influence on the manifestation of this disease, although in this group symptoms were rarely extreme either in their severity or in the displaying of antisocial tendencies.

The Hutterites, by their way of living, seem to be protected from exposure to drugs, unlimited amounts of alcohol, and syphilis, so there is a relative rareness of "organic psychoses."

Among the Hutterites old people enjoy high prestige and com-

munal support, and these factors seem to prevent the extreme social deterioration which sometimes accompanies aging.

Many of the more interesting conclusions deal with psychoneurosis. The authors think the Hutterites react to most stresses with signs of depression rather than with anxiety symptoms, obsessive or paranoid tendencies, as neurotic patients often do in the American culture.

So this study seems to indicate that cultural values and social relations are significant factors in the etiology of psychoneuroses and that in psychoses they are not so important. This seems to favor the theory that neuroses and psychoses are often different processes, in opposition to the theory which claims that they are different grades of the same disease.

The Hutterite people do not rear their children in an environment of permissiveness, which they think to be unwise. Impulsive behavior, masturbation, and aggression are energetically repressed. Nevertheless, parents demonstrate great affection for their children.

Among the Hutterites there seem to be very few personality disorders (people who execute antisocial acts in a repetitive way). The same is observed regarding crimes.

As to treatment, the psychological side is completely disregarded. One contributing factor for this is the high cost of psychotherapy and another the fact that they regard doctors mainly as "doers."

The outlook for mental diseases is generally optimistic. Some psychotic and sociopathic persons are considered "bad" cases. The Hutterites usually demonstrate a great deal of sympathy for the depressed, the defective, and the epileptic.

Finally, the authors ask whether or not the people are healthy. They bring into consideration that health is a value and not a scientific judgment. So it is very difficult to make a statement about this point. Nevertheless, the Hutterites' social system is, according to the writers' opinion, quite healthy.

A. C. Pacheco e Silva

Clinica Psiquiatrica
Sao Paulo, Brazil

Good Health for You, Your Family and Your Community. By Nelson S. Walke, Ph.D., Nathan Doscher, LL.B., Ph.D., and Glenna Garratt Caddy, M.D. New York, McGraw-Hill, 1955. 415 p.

Judging from the preface, the authors of this book sought to emphasize that although the factors which contribute to health and healthy living can be divided into major categories, these categories are thoroughly interdependent. They therefore sought to examine these many different health factors and their interrelationships with

other significant influences in order to arrive at an accurate concept of total healthful living. For this reason the authors discussed, in a surprisingly condensed manner, elements of genetics, medicine, law, biometry, demography, epidemiology, dentistry, public health, disaster control, anatomy, physiology, recreation, family life preparation, to mention only a few, and classified them under three main headings: the family, the community, and the individual.

To accomplish this task of demonstrating the multi-ordinality of health, the authors adopted the clipped, concise, authoritative, almost topical style of a textbook. This enabled them to furnish an encyclopedic review of respected opinion and accepted facts under a multitudinous number of subject headings in the least amount of space. For example, only two pages were devoted to the subject of juvenile delinquency, three-fourths of one of these being used for a statistical table.

Some professionals in the field of health and physical education might find the content too elementary; the style, though lucid, necessarily dogmatic; and the language too filled with unmodified statements for their tastes. But they would probably admit that this book can fill a real need among certain groups of intelligent citizens. There is also a possibility that some non-professional readers might find the integration of varied health factors difficult to achieve because of the many subjects discussed.

Nevertheless, the book can be readily recommended for use as a textbook in courses on health in secondary schools and colleges, in adult education, and in citizens discussion groups. It could also be successfully employed in schools of nursing and social work, and in introductory courses on family health in medical schools. The excellent index and subject structuring of the contents, together with listing of pertinent facts and statistics in the text, and an adequate bibliography at the end of each chapter also extend its usefulness as a book of ready reference for the busy teacher or lecturer who is frequently confronted with the need for a source of definitive opinions and facts on the many aspects of health to refresh his basic knowledge in the field.

A major feature of this book, to be found at the end of every one of its twenty-three chapters, is the listing of a number of questions under the heading of "Problems." These questions, of the type customarily asked in examinations, deal with the content of the previous chapter. They have been carefully prepared to provoke honest thought and personal effort, and cannot be easily answered without really knowing the subject. They lend themselves readily for "homework" or for group discussions.

The authors have made a painstaking effort to assemble and syn-

thesize in but 400 pages a vast compendium of up-to-date scientific material concerning the total health of the individual, family, and community, utilizing the many contributions of related sciences in a condensed but very lucid style and easily understood vocabulary.

GEOFFREY W. ESTY, M.D.
New Jersey State Department of Health

THE LIFE AND WORKS OF SIGMUND FREUD. 1901–1919: Years of Maturity. Vol. 2. By Ernest Jones, M.D. New York, Basic Books, 1955. 512 p.

The second volume of Ernest Jones' biography of Freud is magnificent. In some respects the account of the years of maturity surpasses that of the formative years. The author's clear, concise writing is particularly evident in part 2 of the volume, in which he succinctly and brilliantly abstracts and evaluates all of Freud's writings published between 1901 and 1919.

In his effort to make his work the definitive biography of the master, Jones at times, in the first part of the volume, goes into minutiae that are unnecessary. He supplies the names of the hotels at which Freud stayed during his many short excursions and several times even details what he paid for his rooms.

There are many illuminating observations about the early leaders in the psychoanalytic movement and much material that is of great historical importance, particularly in the relationship of Freud and Jung. It is interesting, in the light of the increasing requirements for personal analysis of those who are today in training, to learn that such leaders as Abraham and Ferenczi had little or no personal analysis. Jones, in retrospect, seems to feel that this deficiency was in large part responsible for the defections of Jung, Adler, Stekel, and others, and for the bitter animosity that they displayed toward Freud. Of this, the reviewer must be somewhat skeptical in light of some of the internecine activities that have taken place in some of our American psychoanalytic societies, by men who had had prolonged analysis.

Freud emerges from this volume as a giant, but remains an enigma. In many respects he has more of the makeup of the artist than the scientist. Few individuals could have had more complex personalities; his character was full of paradoxes. Despite his lust for truth and his independence of commonly accepted beliefs, he clung to superstition, such as the one that he was to die in February, 1918. He harbored prejudices against the Swiss and against Americans and America. At the outbreak of World War I, he wholeheartedly accepted the justice of the cause of Germany and its allies. He opposed the restrictions that western culture has placed on sexual

expression outside of marriage, yet few men have led such a monogamistic life. He had little vanity and never had a wardrobe of more than three suits, but he had a barber come daily to his home to trim his beard and he hated to be considered old. Despite his uncanny penetration into the deepest structures of his patients' personalities, Jones maintains, apparently with justification, that Freud was not an astute judge of people. The volume ends with the author's bold attempt to find the secret of Freud's genius. He analyzes his personality and the early influences that molded him. This reviewer finds the author's conclusions quite unconvincing.

With his great moral courage, his compelling sense of fairness, and his intellectual daring, Freud stands out among contemporaries like one of the great biblical prophets of old.

The psychiatric world awaits Jones' final volume with intense eagerness.

MANFRED S. GUTTMACHER, M.D.

Baltimore, Md.

MATERNAL EMOTIONS.. By Niles Newton, Ph.D. New York, Harper & Brothers, 1955. 140 p.

To live with our human emotions is both puzzling and often difficult. To attempt to scrutinize any segment of such emotions with scientific objectivity and the application of statistical techniques takes vision, skill, and courage. Niles Newton deserves recognition for all of these. In addition she should win acclaim from all thoughtful members of the fairer sex for her dedication to "helping women to have better health and more satisfying lives."

Dr. Newton's contribution toward this goal is made by questioning systematically in the rooming-in wards of the Jefferson Hospital a group of 123 mothers of newborn babies. Eighty-four percent of these mothers were Negroes. The interviews were conducted personally by Dr. Newton, who attempted to discover how these women felt toward vital areas of their living: menstruation, pregnancy, childbirth, breast feeding, rooming-in care of their baby, satisfaction in woman's role in life, wish to be a man, and, in a few instances, attitudes toward sexual intercourse. Feelings of satisfaction or dissatisfaction in each of these categories were compared to information on the medical record concerning the individual mother's health, the ease or difficulty of her menses, the pregnancy, the birth, and the breast feeding of the child. The results were tested for statistical significance and include a group of specific and suggestive findings. In addition, the author reviewed and included in her discussion a large variety of ideas and facts from related experiments and reports.

In the concluding pages of the book all of this material is helpfully

summarized (p. 102). "These studies almost all," states Dr. Newton, "tend to show the same general thing—that woman's feelings and emotions toward her wider sexual role are often related to her behavior, her attitudes, and her health. In general, but not always, positive feelings are more likely to be associated with good health and well-being, whereas negative feelings are more likely to be associated with poor health and dissatisfaction."

If these findings are valid for women in general, they merit the gravest consideration by parents and educators. Does our present training at home and in school tend to foster closer identification on the part of our girls and young women with their biological functions? Does it foster greater acceptance of the creative and important aspects of their role as wives and mothers, rather than as competitors with men for jobs? Does it foster confidence and joyfulness in themselves as women rather than abet them in imitating the attitudes and activities of men? Do we by these and other means aid in decreasing conflicting values for women and thus increase their mental health?

Dr. Newton makes no claim to final knowledge in her study and assiduously defines the group with whom she worked as not typical. It is obvious that one cannot with reliability apply the results of a study conducted primarily with Negroes from a low economic classification to white women of college education. Another point which apparently the author did not take into consideration is whether a particular woman's attitude toward the questions studied may vary from one pregnancy to another. In my own clinical and research experience in the field of marriage counseling, we have learned that the way a woman feels about her marriage may very definitely alter the way in which she sees her husband. If she feels happy and contented in her marriage and in her love for her husband, the expectation would be that she would be much more apt to be happy and contented in relation to planning for a child. There is also the possibility that a woman's attitude toward her first pregnancy might be quite different than her attitude toward a seventh. One could wish that Dr. Newton had asked these women what their feeling was about this pregnancy—in other words, was it a wanted or unwanted condition? We have known of a dramatic shift in a woman's health in connection with pain at menstruation, comfort during pregnancy, attitudes toward birth, etc., when a women is living with a man who loves her and whom she loves as compared to an experience when she was married to someone whom she cordially disliked. In this connection we might note in passing that 28 of the mothers studied were unmarried or separated. It does not seem illogical to expect that such mothers might at that time harbor fairly strong feelings of

resentment toward men and toward themselves as women. It would be interesting to be able to break down the results in connection with these differences in the group. I also find myself wondering whether a woman's attitude toward menopause would not fit into the same frame of reference of health as the other intimate items studied. In other words, positive feelings toward this condition would be more likely to be associated with good health and well-being, negative feelings with poor health and dissatisfaction.

Another small point deals with Dr. Newton's statement that women have lost status rather than gained it with the coming of the industrial revolution. Does the author not refer to loss of status by *married* women? It seems to me that this might be argued, but that single women have definitely gained in their capacity for independence and in their status as wage-earners.

One of the easiest techniques for a reviewer of a book is to ask questions and to wish that the author had extended her study to a wider universe. In this instance, as Dr. Newton herself intimates, one of the most important reactions that her excellent research can accomplish is to stimulate more and yet more questions and point the road to their solution. This reviewer at least hopes that Dr. Newton herself will continue her leadership in exploring the many unknowns and in helping to find the answers.

EMILY H. MUDD, PH.D.

Marriage Council of Philadelphia

HUMAN RELATIONS IN ACTION. By H. Edmund Bullis, A.B., M.E., and Cordelia W. Kelly, R.N., B.S. New York, G. P. Putnam's Sons, 1954. 86 p.

Human Relations in Action is a recent addition to the handbooks prepared for the use of administrators, supervisors, and others who deal with groups of workers. It is a comparatively small volume, and the subject matter is presented in fifteen short chapters.

The material is a practical presentation of mental hygiene principles applicable to a wide variety of students and employees. The importance of understanding the nature and value of emotions is stressed, and the explanatory text is interesting and convincing.

Shop foremen, supervisors of workers in industry, store operators, and those directing transportation workers, as well as hospital administrators and community health workers, may apply the teachings presented.

Nurse instructors will find it of value in presenting mental health concepts to student nurses and graduate staff. Those responsible for in-service education of ward personnel in mental and general hospitals will find it a valuable source of illustrative and explanatory subject

matter. Case studies are presented in the various chapters, and discussion or dissection of the problem, leading to suggested solutions, provide interest.

Chapters one through four explain in easily comprehended terms the emotional forces underlying our behavior and the motives for our actions. The acceptance of one's self, with recognition and acceptance of limitations and possibilities, is given first place and sets the tone for wholesome reflection established in the text.

The enjoyment provided by emotions and their influence on an individual's acceptibility as a companion, friend, or fellow-worker are presented with suitable stress. "Learning To Be Likable" and "Personality Assets and Liabilities" are chapter titles that will attract readers. "Leadership" and "Making and Keeping Friends" also are of absorbing interest, and the counsel provided is applicable.

Direct advice is provided concerning relaxation and the value of good morale and of meeting emotional and other problems honestly and without subterfuge. These delicate subjects are treated straightforwardly.

Each chapter includes questions for discussion or thought-provoking items.

This unpretentious, easily read handbook provides intellectual stimulation of value out of proportion to its size. The authors are well-versed in their subject and have presented it to appeal to a wide variety of readers.

An index would increase the book's usefulness.

MARY E. CORCORAN

Harrisburg, Pa.

NOTES AND COMMENTS

Turning Point Reached in Fight against Mental Illness

The turning point in the nation's drive against mental illness was very probably reached in 1955, according to F. Barry Ryan, Jr., president of the National Association for Mental Health.

Summarizing important events of last year in the NAMH annual report, released April 22, Mr. Ryan described 1955 as "a year of exceptional progress." But despite gains, he warned, the nation's # 1 health problem will not be conquered until a Citizens' Army against Mental Illness is mobilized, similar to the citizens' movements which have helped stem other serious illnesses.

NAMH, consisting of 500 local and state mental health associations, is now in the process of recruiting such an army, Mr. Ryan emphasized. He pointed out that public education through newspapers, magazines, TV and radio has made the public better informed on mental illness than ever before and "ready for the first time to give mass support to science's efforts to combat mental illness."

Noting other gains, Mr. Ryan reported:

Last year 38 states increased their appropriations for the care and treatment of mental patients, primarily to obtain sorely needed personnel.

Congress created a Joint Commission on Mental Illness—representing 18 major national organizations including NAMH—and authorized a $1,250,000 fund for a three-year investigation into all aspects of mental illness.

As deficits, Mr. Ryan noted that the majority of the nation's 750,000 mental patients still receive little or no treatment, many states still jail patients before admitting them to mental hospitals, and the increased rate of discharges from hospitals as a result of drug therapy intensifies the problem of inadequate rehabilitation facilities and after-care services.

Reporting considerable organization growth since 1950, Mr. Ryan said NAMH now consists of 35 state and 470 local mental health associations, compared to 18 state and 150 local groups in 1950.

Nationwide Study Gets Underway

The Public Health Service has approved the application of the Joint Commission on Mental Illness and Health for grant support of a nationwide study of the human and economic problems of mental illness and an initial grant of $250,000 has been awarded for support of the project for the first year. Approval of the grant follows favor-

able recommendation of the application by the National Mental Health Advisory Council.

The award carries out the mandate of the Mental Health Study Act (Public Law 182) authorizing the Surgeon General of the Public Health Service to award qualified non-governmental organizations a total of $1,250,000 in grant allotments over a period of three years to undertake an "analysis and re-evaluation of the human and economic problems of mental illness." The legislation, passed by Congress last year without a dissenting vote, requires recipients to file annual reports and a final report with the Congress, the Surgeon General, and the State Governors.

Dr. Jack R. Ewalt, clinical professor of psychiatry at Harvard and also commissioner of the Massachusetts State Department of Mental Health, is directing the study from headquarters in Boston. Organization of the survey staff has been progressing.

The Joint Commission of Mental Illness and Health was incorporated in the District of Columbia in August 1955. Its membership includes representatives of the American Medical Association, American Psychiatric Association, and other organizations and agencies with a major interest in the social, legal, scientific, clinical, and psychological aspects of mental illness. Many other organizations with related interests will also be asked to participate in the work of the Commission. Of the fifteen members on its board of trustees, five persons are designated by the American Medical Association, five by the American Psychiatric Association, and five by the following organizational members: American Association of Psychiatric Social Workers; American Hospital Association; American Psychological Association; Coordinating Council of American Nurses' Association and National League for Nursing; and the National Education Association.

Dr. Kenneth E. Appel, professor of psychiatry at the University of Pennsylvania School of Medicine, is president of the Joint Commission on Mental Illness and Health, and Dr. Leo H. Bartemeier, chairman of the Council on Mental Health of the American Medical Association, is chairman of the Commission's board of trustees.

It was Dr. Appel, as president of the American Psychiatric Association three years ago, who first called for what he described as a "Flexner-type" study of present methods and practices for dealing with the mentally ill which would lead to a fundamentally new attack on the problem. The famed Flexner Report of 1910 revealed the deficiencies of medical training of that era and led eventually to the high levels of medical education today. Dr. Appel's call was vigorously seconded by the Council on Mental Health of the American Medical Association, and together the A.P.A. and the A.M.A. invited

many other organizations to consider the proposal. This was the start of what later emerged as the Joint Commission on Mental Illness and Health.

Dr. Bartemeier recently declared that the Mental Health Study Act of 1955 offers the chance of a lifetime to develop guideposts to point the way to a fundamentally new attack on this staggering problem. He emphasized that the Joint Commission is organized to insure that the intent of the Congress as stated in the Mental Health Study Act is carried out through an interdisciplinary approach to all aspects of the problems of mental illness and health in this country.

The organizational members of the Joint Commission on Mental Illness and Health are the American Medical Association, American Psychiatric Association, American Psychological Association, American Public Health Association, American Association of Psychiatric Social Workers, American Hospital Association, American Bar Association, American Association of Psychiatric Clinics for Children, American Association on Mental Deficiency, American Occupational Therapy Association, American Psychoanalytic Association, Coordinating Council of American Nurses' Association and National League for Nursing, Council of State Governments, Central Inspection Board of American Psychiatric Association, U. S. Children's Bureau, Joint Commission on Accreditation of Hospitals, National Education Association, National Rehabilitation Association, National Institute of Mental Health, National Association for Mental Health, National Mental Health Committee, Office of Vocational Rehabilitation, Social Science Research Council, Veterans Administration, and U. S. Department of Defense.

Educational Campaign Wins Support of Nation

Millions of Americans in thousands of communities turned the eighth annual observance of National Mental Health Week, April 29 to May 5, into a coast-to-coast rally on behalf of the mentally ill. Simultaneously, the nation's 500 mental health associations launched a month-long membership and fund-raising campaign, the biggest ever conducted to fight mental illness.

Both Mental Health Week and the Mental Health Campaign were backed up by a barrage of TV and radio announcements, newspaper and magazine publicity and billboard advertising. Over 100 stations of the CBS-TV network led off the two events April 29 with an hour-long rebroadcast of "Out of Darkness," outstanding television film produced by CBS Public Affairs in consultation with the National Association for Mental Health and the American Psychiatric Association.

At the close of the telecast, sponsored by Wyeth Laboratories, Vice-President Richard M. Nixon called on the country to support the

NAMH in its efforts to help those suffering the tragedy of mental illness. With Miss Martha Rountree, editor and TV producer, as national campaign chairman, members of the state and local mental health associations set out to enlist their neighbors and friends in a Citizens' Crusade Against Mental Illness.

During Mental Health Week, the nation engaged in a sweeping educational campaign. Citizens sponsored hundreds of public meetings, heard Mental Health Week proclamations by scores of governors, mayors and city councils, and read thousands of newspaper features and other publicity.

They toured mental hospitals, honored 88 psychiatric aides for outstanding services to mental patients, attended lectures by psychiatrists and others who work with the mentally ill, saw movies on mental illness and health, heard special sermons on Mental Health Sunday, inspected special library exhibits of publications on mental and emotional problems, and heard hundreds of celebrities appeal on TV and radio and in newsreels for help for the mentally ill.

Dramatic events created acute interest in the problems of the mental patient. In Maryland, Miss Dora Myers, 71, came home after 18 years as a patient in Spring Grove State Hospital. Now, as Maryland's Mental Health Belle of 1956, she is working with community leaders to better the lot of the 750,000 men and women still living out their lives in crowded mental hospitals.

More than 50 senators endorsed a concurrent resolution—introduced by Sen. George A. Smathers of Florida—calling on Congress to encourage support of the Mental Health Campaign and Mental Health Week. In a speech to the Senate March 22 Senator Smathers said, "It is most important that the American people be aroused as never before to the threat of mental illness, and encouraged to organize in their communities in citizens mental health associations to combat mental illness in every way possible. They should be stimulated," he added, "to contribute financially to the work of the National Association for Mental Health, which, nationally and through its local and state mental health associations, has been leading the fight against mental illness."

In Delaware, 81 state-wide organizations joined under the leadership of U. S. Senator John J. Williams, honorary state chairman of Mental Health Week, in co-sponsoring seven public meetings, each highlighting a different aspect of mental health.

In Teaneck, N. J., 125 high school students crowded into an auditorium to be briefed on their responsibilities in their county's campaign against mental illness. "This is the first time young people have been asked to carry the ball for a community-wide campaign," the *Paterson News* reported, "and even though assistance will be

given by the Teaneck Retired Men's Club and the Junior Chamber of Commerce, the drive's success will be a demonstration of what teen-agers really can do when they are given a chance."

In San Francisco, three Hollywood stars and 32 civic and psychiatric organizations called public attention to Mental Health Week in a series of daily luncheons. The stars—comedian Jack Haley, singer Barbara Whiting and Western actor Hugh O'Brian (Wyatt Earp)—are members of the Thalians, movie colony organization whose first big public-service project is publicizing the Mental Health Campaign.

In Washington, D. C., dance group patients of the Dorothea Lynde Dix recreation and intensive treatment center of famed St. Elizabeths Hospital produced the Skitzofollies of 1956, a revue that included such divertisements as a Rorschach ballet.

In Chicago, more than 1,300 mental health workers, leaders of both houses of the Illinois legislature, representatives of state-wide civic groups and private citizens attended the eighth annual Illinois Mental Health Dinner.

In New York City, the mental health associations of five boroughs pledged to Mayor Robert F. Wagner "their energy, thought and funds to the prevention and relief of mental illness" and certified that they will "press forward in education, research and community service for the benefit of the 8,000,000 people who live and work here."

And in Milwaukee, a revue produced by high school seniors revealed "the hopes, fears and dreams of young people as they seek to find themselves through self-expression." *The Milwaukee Sentinel* called the show "a fitting climax" to a long list of activities in Mental Health Week.

Pay Tribute to Dr. Marion E. Kenworthy

Hundreds of leading psychiatrists, social work educators and practitioners, and prominent citizens paid tribute in New York City, May 7 to Dr. Marion E. Kenworthy, one of the nation's most renowned psychiatrists and a pioneer educator in psychiatry, social work, and mental health.

The annual Founder's Day celebration of the New York School of Social Work, Columbia University, marked Dr. Kenworthy's retirement in June as professor of psychiatry after 36 years of distinguished and dedicated service on the faculty. Kenneth D. Johnson, dean, announced that friends and admirers of Dr. Kenworthy are contributing sums sufficient to endow a $400,000 Marion E. Kenworthy Professorial Chair in Psychiatry at the school.

Dr. William C. Menninger of the Menninger Foundation, Topeka,

Kansas, was the principal speaker at the ceremonies honoring Dr. Kenworthy.

On learning of Dr. Kenworthy's imminent retirement, President Eisenhower recently wrote her, in part: "Now—on the eve of your retirement from the New York School of Social Work—I want to assure you of my gratitude for your distinguished contribution to a great university and for your long and dedicated service to the welfare of our country.

"You, through many years, by your selfless labors, have moved men and women alike to a deeper realization of their responsibilities as Americans and a more effective discharge of them. With all those who have come to know and admire you as teacher and friend and leader, I join in congratulations on a great career and best wishes for the future."

Among the countless inspiring contributions Dr. Kenworthy has made in her career on behalf of the American public were her devoted war services. As a civilian during World War II, she helped to improve recruitment and selection procedures, win specialty status for psychiatric social workers in the armed forces, and modernize military psychiatry generally. Army Chief of Staff General George C. Marshall appointed her in 1944 to the then newly-created National Civilian Advisory Committee to the Women's Army Corps (WAC). During the Korean War, Assistant Secretary of Defense Anna M. Rosenberg organized the Defense Advisory Committee on Women in the Services, to which Dr. Kenworthy was appointed and on which she still serves.

A graduate of Tufts (she received her M.D. with honors in 1913), Dr. Kenworthy soon after became the first woman physician at Gardner (Mass.) State Colony for chronic mental patients. She simultaneously worked and studied at Boston Psychopathic Hospital with a brilliant constellation of psychiatrists. Among them were Karl A. Menninger, of the Menninger Clinic; Karl M. Bowman, of American Psychiatric Association, professor of psychiatry at the University of California and director of the Langley Porter Clinic in San Francisco; the late Frankwood E. Williams, of the National Association for Mental Health; the late Herman Adler, director of the Institute for Juvenile Research in Chicago; Harry C. Solomon, director of the Boston Psychopathic Hospital and professor of psychiatry at Harvard; and Lawson G. Lowrey, pioneer in child guidance work.

In 1921 Dr. Kenworthy first began to teach regular psychiatric courses at the New York School of Social Work, the first institution of its kind in the country. It was a decisive year for her. She had received a training analysis from Otto Rank—before his break with his mentor, Sigmund Freud—on his first visit to this country. Thence-

forward she practiced psychoanalysis (as a Freudian, not a Rankian), and her teaching stemmed from this dynamic orientation. When she retires, Dr. Kenworthy will have finished the longest continuous association as a psychiatrist on a social work school faculty in the annals of American psychiatry.

At the New York School, Dr. Kenworthy underscored and advanced four contemporary trends: (1) the study of the child for clues to the dynamics of human behavior; (2) the shift toward the preventive ideal in approaching problems of delinquency and emotional disturbance; (3) the development of the "teamwork approach," centering mainly around the psychiatrist, the psychologist, and the social worker in the study, diagnosis, and treatment of human behavior problems; (4) the training of social workers acclimated to this clinic team setting.

It is estimated that Dr. Kenworthy has taught more than 10,000 students, many of whom became leaders in their fields—deans and faculty members of social work schools, heads of welfare agencies, community executives. Students have come from across the nation to attend Dr. Kenworthy's classes.

Dean Johnson paid tribute to Dr. Kenworthy's brilliant career in observing: "Marion belongs to that immortal tribe of teachers whom students remember vividly throughout their lives. No one of our faculty has had a greater or more sustained impact on our students."

PTA Recommends Continuous Health Supervision

The National Congress of Parents and Teachers has adopted a policy supporting and encouraging continuous health supervision of children from birth through their school years, rather than a single appraisal when they enter school. Following recommendations adopted by the board of managers May 24, 1956, the Congress will recommend to local PTA groups a promotional and educational program that "will tend to bring children and their parents into effective contact with the health resources of the community."

Essential elements of continuous health supervision, they point out, include, among other factors, evaluations of the child's physical, mental, and emotional development, adjustment and deviations; consultation with parents on the management and prevention of behavior and personality problems, and on plans for treatment; and referral to appropriate services when necessary.

Meanwhile, the Welfare and Health Council of New York City has launched a study of the "great need for a coordinated mental health program for school-age children." Dr. Ray E. Trussell, chairman of the council's survey advisory committee, said the study is part of a three-year survey to determine the effectiveness of the city school

health service in placing children with health problems under care and in improving methods of referral for proper and timely treatment. The mental health study will focus on screening and detection through teacher observation and other techniques.

Drugs Hasten Discharge of Long-Term Patients

Discharges of former chronically ill mental patients after treatment with tranquilizing drugs increased 36 percent at the Northampton (Mass.) Veterans Administration Hospital, according to a survey released in June. The hospital reported that 118 patients were discharged during the last six months of 1955, when extensive drug treatment was given, compared to 86 discharged during the last six months of 1954, when few patients received tranquilizing drugs (chlorpromazine and reserpine).

Among patients hospitalized five years or longer, the percentage of improved cases was higher for those treated by drugs than for those receiving other types of treatment, according to Dr. Lionel M. Ives, director of professional services at the hospital. Thirty-three long-term patients were discharged in the last half of 1955 compared to 19 the year before without benefit of drugs, a 77 percent increase.

Of 533 patients receiving various types of psychiatric treatment, 202 were treated with tranquilizing drugs. Of the 202, 76 percent showed improvement. The percentage of improvement in those treated with the tranquilizing drugs was considerably higher than among those given other types of psychiatric treatment. Many of those successfully treated with drugs had failed to improve under other types of treatment.

The other forms of psychiatric treatment studied were found effective to the following degrees: insulin, 59 percent; electric shock, 54 percent; lobotomy, 46 percent.

The group surveyed ranged in age from 18 to 69 years and had been hospitalized from one month to 30 years.

Where formerly these seriously ill long-term patients were hyperactive, destructive, and in need of restraint, after drug treatment their tensions were reduced and they expressed new interest in their surroundings, with a definite desire to be cured completely.

Dr. Roche Honored

Dr. Philip Q. Roche, Philadelphia psychiatrist, received the Isaac Ray Lectureship Award of the American Psychiatric Association at the APA's annual meeting in Chicago April 30–May 4. The award is given annually to a lawyer or psychiatrist for contributing importantly to better understanding between law and psychiatry.

As winner of the $1000 award, Dr. Roche will deliver a series of

lectures on psychiatry and the law at the University of Michigan, under the joint sponsorship of the law and medical schools there. These will later be released in book form by Farrar, Straus & Cudahy, publishers.

Just prior to World War II, Dr. Roche, as chairman of a joint commission of the Philadelphia County Medical Society and the Philadelphia Bar Association, was largely responsible for the widely praised Pennsylvania plan for intramural training in penal psychiatry. Supported by the Commonwealth Fund, the plan provided fellowships for training physicians in penal psychiatry at Eastern State Penitentiary in Pennsylvania. It operated for two years but was discontinued when the war broke out.

Dr. Roche was chairman of the committee on forensic psychiatry of the Group for the Advancement of Psychiatry from 1948–1952, and has been a member of the APA committee on legal aspects of psychiatry since 1942. He has served on the Philadelphia Advisory Commission on Commitment, Detention and Release of Prisoners, and was a founding member of the Philadelphia Medical Legal Institute. His contributions to the literature include articles on the relation of syphilis to crime, masochistic motivation in criminal behavior, community control of sex offenders, sexual deviations, and many other topics. In 1952–1953 he conducted a seminar on psychiatry and the law at the University of Pennsylvania Law School.

A graduate of the University of Michigan Medical School, Dr. Roche is a fellow of APA and a member of the American Psychoanalytic Association. He is on the faculty of the University of Pennsylvania School of Medicine and the Philadelphia Psychoanalytic Institute. He was a founding member of the Pennsylvania Psychiatric Society and served as its president in 1952–53.

Dr. Roche is the fifth winner of the award, the others being Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital, Washington, D. C.; Dr. Gregory Zilboorg, New York City psychiatrist; Hon. John Biggs, Jr., Chief Judge, U. S. Court of Appeals, Wilmington, Del.; and Professor Henry Weihofen, College of Law, University of New Mexico, Albuquerque. The award commemorates Dr. Isaac Ray, a founder of the APA, whose *Treatise on the Medical Jurisprudence of Insanity* published in 1838 was for many years the standard work on the subject.

Texas Paper Wins Bell Award

The Austin (Texas) *American-Statesman* received the National Mental Health Bell Award for 1955 in ceremonies May 2 in Austin. The award, a bronze facsimile of the Mental Health Bell mounted on a walnut plaque, is given each year by the National Association for

Mental Health to an American daily newspaper making an outstanding contribution to the fight against mental illness.

Factors considered in selecting the award-winner included: dissemination to the public of mental health news, information and opinion; publicizing and editorially supporting local, state and national mental health programs, objectives and fund drives; leadership in campaigns to secure new or improved mental health services for the prevention and treatment of mental illness; any other editorial contributions to the fight against mental illness and the advancement of good mental health.

Day Hospitals

At the end of ten years' operation, the day hospital which was first established in the Allan Memorial Institute, Royal Victoria Hospital, Montreal, has been reviewed. It has been exceedingly successful and similar day hospitals have now been established in Canada, the United States, and Britain. Patients come from 9:00 a.m. to 5:00 p.m. each day except Sunday. All types of patients that can be admitted to a day and night division of a general hospital can be accepted in a day hospital, and all forms of treatment, with the possible exception of coma insulin, can be carried on in the day hospital. The cost to the patient is about one-half to one-third of that to the patient who has to reside overnight.

The first of two day hospital centers to be organized by the New York State Department of Mental Hygiene opened at Hudson River State Hospital, Poughkeepsie. The day hospital is a pilot project to determine the value of psychiatric and supportive therapy for suitable mental patients in a hospital during the daytime. Patients at the new center will receive psychiatric care on a voluntary outpatient basis, during the day, remaining for the rest of the time at their homes or continuing insofar as possible with their family and community activities.

The second day hospital will open in the near future in connection with the Brooklyn Aftercare Clinic.

The Hudson River day center occupies one ground floor wing of a new building. The wing has a separate front entrance and forms a self-contained unit independent from the hospital and the rest of the building. It consists of sixteen rooms with ample physical facilities for all types of therapies, offices, and reception services. The treatment area will consist of a treatment unit with ten beds, an occupational therapy studio, and a rehabilitation area including a library and recreation room. Dining facilities also will be available.

The day hospital has been designed for the care of adults eighteen years or older and will operate five days a week from 8:30 a.m. to 4:00

p.m. All standard psychiatric and somatic therapies, including drugs, electric shock, and insulin will be given.

Patients will be referred to the day hospital primarily by community physicians and social agencies and on a volunteer basis. Cases also may be accepted after provisional release from a state hospital to complete the patients' course of treatment or for social and vocational readaptation as a means of helping to tide them over in making an adjustment from the hospital to the community. In both cases, much stress will be laid on the closest possible cooperation with the community and the patients' families, employers, or friends. No rigid rules have been set up to govern admissions, but each case will be evaluated on its individual merits depending on the type and degree of resocialization expected.

A staff of fourteen will administer the day hospital, headed by Dr. O. Arnold Kilpatrick, director of the Hudson River State Hospital. Dr. Marian Axel will be the psychiatrist in charge of the center. The staff will also include a psychiatrist, two nurses, a social worker, occupational therapist, recreational worker, two male and four female psychiatric aides, and a secretary-receptionist.

Establishes National Awards

Marshall Field announced today the formation of Marshall Field Awards, Inc., a non-profit organization "to recognize and reward fundamental and imaginative contributions to the well-being of children." Six to nine awards will be made annually to individuals, organizations, and communities in the fields of education, physical and mental development, social welfare and communications. Each award will consist of $2,000, a scroll, and a statuette. The winners will be selected by a board of directors composed of recognized authorities in child life. The first awards will be made this year.

In announcing the awards program, Mr. Field stressed the considerations that led to its establishment: "Although few would quarrel with the controlling importance of children to America's future, I believe we have not done all we can or should to assure for our young people the opportunity for their fullest physical, mental, and social development. I think the reasons for this deficiency are, first, that we have not devoted a large enough portion of our national resources in manpower and money to the professional fields which serve children and, second, that we have not made those professional fields sufficiently high in prestige or reward to attract adequate numbers of top-notch personnel needed to make new and important contributions to the well-being of children.

"Our awards are designed to help meet these deficiencies. It is

our hope that they will focus public attention on children's needs and on the areas in which improved services are urgently required. The awards will call attention to constructive programs which set an example for others to follow. We hope, too, that the granting of these awards will, in some measure, raise the status of the professions devoted to children and will stimulate the making of additional significant contributions to the betterment of child life."

Mr. Field has long been active in work devoted to children both through the Field Foundation, which he established in 1940, and as president since 1951 of the Child Welfare League of America.

Nominations for possible award winners will be solicited by the new organization on a nation-wide basis. All nominations will be screened and final selections will be made by the board of directors. International awards may also be granted at the discretion of the directors.

The following criteria will be used in judging work nominated for awards: 1. Does it directly help children (defined as those who have not yet reached legal majority)? 2. Does it benefit a large or significant group of children? 3. Can it be applied or adapted for use by others? 4. Is it consistent with professional standards in the field? 5. Does it represent an original or extraordinary service? 6. Will it promote sound development of children? 7. Will it stimulate public interest in the needs of children? 8. Does it open new dimensions in the lives of children? 9. Is it being recognized nationally for the first time? 10. Are those who did the actual work being rewarded?

Members of the board of directors in addition to Mr. Field are: Leona Baumgartner, M.D., New York City Commissioner of Health; Mrs. Richard J. Bernhard, president, Arthur Lehman Counseling Service; Sarah Gibson Blanding, president, Vassar College; James Brown, IV, executive director, Chicago Community Trust; Hon. Ralph J. Bunche, Under Secretary Without Department, United Nations; Martha M. Eliot, M.D., chief, U. S. Children's Bureau; Ruth Pruyn Field, New York City; Leonard H. Goldenson, president, American Broadcasting-Paramount Theatres; John Gunther, New York City; Herold C. Hunt, Under Secretary of Health, Education, and Welfare; Charles A. Janeway, M.D., professor of pediatrics, Harvard University Medical School; Clark Kerr, chancellor, University of California; Mrs. David M. Levy, president, Citizens' Committee for Children of New York City; Ernest K. Lindley, director, Washington Bureau, Newsweek; Leonard W. Mayo, director, Association for the Aid of Crippled Children; William C. Menninger, M.D., Menninger Foundation; Hon. Justine Wise Polier, Children's Court, New York City; Mrs. Anna M. Rosenberg, New York City; Howard A. Rusk, M.D., associate editor, New York Times.

Offices for the new organization have been opened at 598 Madison Avenue, New York City. The deadline for nominations for the first awards is October 1, 1956.

NAMH, NIMH Announce Research Grants

Grants totaling $82,900 for 22 research projects on schizophrenia were announced May 6 by F. Barry Ryan, Jr., president of the National Association for Mental Health. The grants were made from a $100,000 fund provided by the Supreme Council, 33rd Degree, Scottist Rite Freemasonry, Northern Masonic Jurisdiction, which is directing the research program through the National Association for Mental Health. In the last 22 years, the Scottish Rite has provided more than $1,100,000 for this continuing research program.

Forty-two new research grants were recently awarded by the National Institute of Mental Health on the recommendation of the National Advisory Mental Health Council. The new awards, totaling just under $700,000, went to the support of 42 approved projects at academic, scientific, and medical centers throughout the country. The Advisory Council also approved continuation of 102 research grants totaling $1,713,272.

The following grants were announced by the NAMH:

Dr. Kenneth Appel, Institute of the Pennsylvania Hospital, Philadelphia, for an investigation of the effects of carbon dioxide treatment in early schizophrenia; $5100.

Dr. Philip Bard, Johns Hopkins University, Baltimore, for an experimental study of aggression and anger in animals; $1000.

Dr. George H. Bishop, of Washington University School of Medicine, St. Louis, for a study of brain interconnections through the use of small electrodes to record the electrical impulses from the brain in response to stimuli; $2500.

Dr. C. H. Hardin Branch, University of Utah, for an investigation of urinary metabolic abnormalities in schizophrenic patients; $5000.

Dr. Robert Allen Cleghorn, McGill University, Montreal, for the assessment of neurohumoral and endocrine functions in schizophrenia; $4000.

Dr. Daniel H. Funkenstein, Boston Psychopathic Hospital, for an investigation of stress reactions and schizophrenia; $4000.

Dr. Hudson Hoagland, Worcester Foundation for Experimental Biology, Shrewsbury, Mass., for a study of the relation of adrenal function to schizophrenia; $5000.

Dr. Irving Kaufman, Judge Baker Guidance Center, Boston, for a study of pre-schizophrenic children, involving a careful study of the psychological problems of the child's mother, which has a serious impact upon his personality development; $4800.

Dr. Franz J. Kallman, New York State Psychiatric Institute, for twin and sibship study of pre-adolescent forms of schizophrenia; $4000.

Dr. Peter H. Knapp, Boston University School of Medicine, for an investigation of the relation of asthma to schizophrenia; $4000.

Dr. Zygmunt A. Pietrowski, New Jersey Neuropsychiatric Institute, Princeton, for a study of projective techniques in early schizophrenia; $3000.

Dr. Marian Putnam, James Jackson Putnam Children's Center, Roxbury, Mass., for an investigation of the effects of adverse childhood experiences in undermining personality and rendering the individual susceptible to mental illness; $4500.

Dr. Ralph D. Rabinovitch, Neuropsychiatric Institute, University of Michigan, Ann Arbor, for a study of childhood schizophrenia; $4000.

Dr. Carl Schmidt, University of Pennsylvania School of Medicine, for a study of the utilization of oxygen by brain tissue; $3000.

Dr. Heinrich Waelsch, New York State Psychiatric Institute, for the study of chemical changes involving nuclear protein in schizophrenia; $3000.

Dr. Alfred Washburn, Child Research Council, University of Colorado, Denver, for studies in the psychological development of children; $5000.

Dr. John C. Whitehorn, Johns Hopkins University, for a study of the personal (psychological) characteristics of psychiatrists that render them more effective or less effective with certain types of patients, especially schizophrenic patients; $5000.

Miss Neta A. Neumann, St. Elizabeths Hospital, Washington, D. C., for a study of the part played by basal ganglia structures in the development of schizophrenia (the basal ganglia are masses of cells deep in the brain tissue, separate from the cortex; they are, among other things, heavily involved in emotional expression); $4000.

Dr. Ian Stevenson, Louisiana State University School of Medicine, New Orleans, for an investigation of certain psychological and biochemical aspects of schizophrenia and experimental psychoses, using lysergic acid and other drugs that bring about hallucinations artificially; $6000.

Dr. Francis J. Gerty and Dr. Ivan Boszormenyi-Nagy, Neuropsychiatric Institute, University of Illinois, Chicago, for a study of the diagnostic aspects of unusual chemical changes going on within the red blood cells of schizophrenia patients; $3500.

Professor Erwin Chargaff, Cell Chemistry Laboratory, Columbia University College of Physicians and Surgeons, New York City, for

research on the nuclear proteins and nuclear acids of the brain. These are the peculiar chemical components of the nuclei of cells; $2000.

Dr. George L. Engle, University of Rochester, to provide stipends for students between the third and fourth year of medical school at the University of Rochester to work in the field of research during the summer and thereby receive training in the methods of research; $500.

Dedicates Pavilion at St. Elizabeths

Pointing out that mental illness took an annual toll of nearly $2,000,000,000 from the nation's economy, Vice-President Richard M. Nixon dedicated the new Dorothea Lynde Dix pavilion of St. Elizabeths Hospital in Washington, D. C., April 13.

He added that it was fitting that the $6,000,000 building, designed to return patients to community life as quickly as possible, should be named for the woman who pioneered enlightened hospital treatment. He also linked the dedication with the observance of National Mental Health Week April 29 to May 5.

Features of the federal hospital's new facilities include lightweight upholstered furniture, reproductions of art masterpieces in all rooms, window screens instead of bars, a patio for summer parties, and barber shops where men patients may shave themselves.

New Procedure to Speed Grants

The Public Health Service has announced a new procedure to expedite the processing of research grant applications for requests which do not exceed $2,000 plus indirect costs and which do not ask support for more than one year. Such applications will be accepted and processed on receipt and are not therefore subject to the usual deadlines for submission prior to review. Council recommendations can be expected on these applications within one to four months from the time of submission. These procedures do not apply for requests for supplements to existing grants. Address all applications as well as requests for forms or additional information to the Division of Research Grants, National Institutes of Health, Bethesda 14, Md.

To Attend Conference

Mrs. Evelyn D. Adlerblum of New York City will represent the National Association for Mental Health and the New York University School of Education this summer at an international conference on education and mental health in home, school and community. The conference will meet in Utrecht, Holland, July 28 to August 9. Mrs. Adlerblum, an assistant professor of education at NYU, originated

practical techniques for applying mental health concepts in kindergarten and the first grade.

Los Angeles Hospital Opens Psychiatric Department

First patients in Mt. Sinai Hospital's new psychiatric department were admitted April 16, according to Dr. Franz Alexander, chief of psychiatry and director of the Los Angeles hospital's Psychiatric Research Institute. With the opening of the new facility, Mt. Sinai becomes the only non-governmental hospital in Southern California to provide free and part-pay beds for mentally and emotionally disturbed adults. Thirty-five beds will be available for patients, half of them free. Dr. Alexander stressed that the patient will be treated as a whole person, receiving care for physical as well as mental needs. Patients may be treated by their own psychiatrists while hospitalized at Mt. Sinai, but all care will be under supervision of the hospital staff and a uniformity of standards will be observed. Twenty-four psychiatrists, headed by Dr. Steven D. Schwartz, chief of inpatient service, have been appointed to the staff, and all have agreed to provide free care to patients in need.

The hospital's psychiatric outpatient clinic is expected to be in operation by the end of the summer.

Mt. Sinai also is undertaking a major psychiatric research program. The Psychiatric Research Institute is investigating the basic psychological and biological causes of mental illness and emotional disturbances.

New York Mental Hospitals Note Population Decrease

For the first time since World War II the records of the New York State Department of Mental Hygiene show a decrease in the number of mental hospital patients.

Reporting to Governor Harriman at the close of the fiscal year, Dr. Paul H. Hoch, commissioner, pointed out that while there has been no essential change in the number of admissions, there has been a sufficient increase in the number of releases during the last fiscal year not only to offset the admissions but to effect a slight decrease in the net population. For the past ten years the resident population of the mental hospitals has been increasing by about 2,000 patients each year. On March 31, 1956, however, the resident population (92,916 patients) was actually 500 less than it was on March 31, 1955. The difference lies in the fact that during this period there was an increase of 2,600, or 23 percent, over the previous year in the number of patients released from the hospitals.

The improvement in release rates was attributed by Dr. Hoch to

intensified treatment, including more extensive use of tranquilizing drugs. There may be other factors, he said, which are not measurable at this time.

"While these statistics are most encouraging," Dr. Hoch warned, "it is too soon to know whether they represent an actual alteration in the rising trend or merely a temporary fluctuation. Certainly the decrease is insufficient to have any validity at this time as an indication of complete reversal. There is more reason to hope that we may be able just to hold the line—that is, to balance releases against admissions so that as time goes on we will no longer be faced with the appalling necessity of building the equivalent of a new institution every year to accommodate the additional patients. Instead we would be able to use our resources for more treatment, training and research.

"It is still imperative," he declared, "that we continue our present building program. The institutions are still 30 percent overcrowded and many obsolescent buildings must be replaced. Furthermore, we must have proper facilities if we are to provide good modern treatment."

Mental Patient Statistics Show Increases

Mental hospital figures in basic categories showed a "substantial increase" in fiscal 1955 over the year before, according to statistics compiled by the biometrics branch of the National Institute of Mental Health from summary data supplied by the 48 states and the District of Columbia. Increases ranged from 1.2 percent for resident patients at the end of the year to 9.8 percent for readmissions. Other categories showing increases were first admissions (1.9 percent), discharges (2.4), deaths in mental hospitals (4.3), personnel employed full-time at the end of the year (5.1), total maintenance expenditures (9.3), and average expenditure per capita (7.7).

SKF Joins National Health Council

Smith, Kline & French Laboratories, pharmaceutical manufacturers, became the fifty-first member of the National Health Council through vote of the Council's delegates in June. The 115-year-old company is the first pharmaceutical concern to share in the cooperative program of the Council, active members of which are voluntary health organizations and professional societies in the health field. Governmental health agencies are advisory members, and civic groups with health interests hold associate memberships. SKF Laboratories joins two other sustaining members, the Metropolitan Life Insurance Company and the Equitable Life Assurance Society of the United States.

"We are wholly in agreement with the specific goals of the National

Health Council," said Francis Boyer, president of Smith, Kline & French, "and have always felt that association between pharmaceutical firms and ethical health organizations cannot help being beneficial to both parties and to medicine in general." A foundation established by SKF carries on a $125,000-a-year research and training grant program in the mental health field.

The addition brings to an all-time high the membership of the Council which was founded in 1921 by ten organizations. Council activities include an annual National Health Forum. The 1957 Forum, to be held in Cincinnati March 20 and 21, will be concerned with mental health.

Emotional conflicts between dentists and their patients is one of the most difficult problems the dental profession faces today, according to Dr. George W. Teuscher, dean of Northwestern University dental school. As an approach to the problem, Northwestern sponsored a conference June 15 and 16 for faculty members of the nation's dental schools on the care of the child patient.

"There are tens of thousands of children who receive no dental care only because of existing emotional conflicts," Dean Teuscher said. "These conflicts could be corrected with proper management taught in our dental schools. By teaching dentists how to manage children, correct relationships can be established and habits formed early in the child's life."

The two-year-old is not too young for his first visit to a dentist, according to Dean Teuscher.

Speakers at the seminar included Miss Helen Ross, executive secretary of the Chicago Institute for Psychoanalysis, Dr. Ner Littner, child psychologist, and Dr. Harvey Lewis, psychiatrist and anthropologist.

Demands for mental health services in New York City far outrun the capacity of available facilities, the Welfare and Health Council reported in May. The relation of real need to current demands is insufficiently known, the Council says, in calling for a comprehensive survey as the most urgent requirement in the field. J. Donald Kingsley, executive director, urged that the New York Community Mental Health Board sponsor the survey as a basis for sounder planning in the entire field and for allocating funds under the Community Mental Health Services Act.

"In all situations where demand outruns supply, priorities must be determined," Mr. Kingsley said. "At present, we simply do not have the facts to determine sound priorities in this area. The Council report brings together much information on mental health needs

and facilities, but more detailed information is essential for sound planning."

The report outlines an immediate nine-point program for improving mental health and mental health services in the city:

1. A training program for key people in health and welfare organizations and in industry so that they learn enough of the symptoms of emotional disturbance to recognize individuals needing help and to know the resources where help is obtainable.

2. More effective information and referral services, greater coordination among existing services, and more consultation between referral services and diagnostic and treatment agencies regarding in-take policies.

3. Additional outpatient clinic services, especially for children; services for older persons; study of geographic distribution of services; and relation of plans for new services to demonstrated need.

4. Rehabilitation services for patients with psychiatric disorders, including more half-way service, sheltered workshops, and sheltered living environment for emotionally disturbed persons; better vocational service; and greater use of existing vocational advisory and training services.

5. Increased funds for training workers in mental health.

6. Public funds not to replace voluntary fund-raising efforts.

7. Careful study of existing laws and standards for personnel and facilities. (The report noted that the New York State Society for Mental Health has begun a review of laws.)

8. Exploration of all promising approaches toward maintenance, protection, and promotion of mental health, to accumulate tested knowledge in these fields.

9. More liberal interpretation of the scope of the Mental Health Services Act, so that reimbursement for new and expanded services in protection and promotion of mental health will be available as knowledge of these activities increases.

Copies of the statement, titled "Mental Health Needs and Facilities in New York City," will be available at a charge of 50¢ each from the Publications Department, Welfare and Health Council of New York City, 44 East 23rd Street, New York 10.

Two New York City psychiatrists have been named consultants to the New York State Department of Mental Hygiene by Dr. Paul H. Hoch, Commissioner of Mental Hygiene. Appointed to the honorary posts were Dr. M. Ralph Kaufman, chief of psychiatry at Mount Sinai Hospital, and Dr. John Millet, who is affiliated with Presbyterian Hospital. Both men were charter members of the State Mental Hy-

giene Council and recently completed their terms of office after serving five years. Dr. Hoch said they were appointed consultants in recognition of the outstanding services they have performed for the department especially during their tenure on the Mental Hygiene Council.

Dr. M. G. Candau, director-general of the World Health Organization, has announced the appointment of Dr. E. Eduardo Krapf, associate professor of psychiatry at the University of Buenos Aires, as chief of the mental health section of WHO, with headquarters in Geneva. Dr. Krapf, president-elect of the World Federation for Mental Health, has been associated with the National Hospital of Neuropsychiatry and was a psychiatric consultant with the armed forces of Argentina. He obtained his medical degrees at the Universities of Munich and Buenos Aires and holds the titles of professor extraordinary at the University of Cologne and of honorary professor at St. Thomas University, Manila. He succeeds Dr. G. R. Hargreaves in the WHO post.

Organize National Academy of Religion and Mental Health

Following three years of preliminary discussions with psychiatrists, theologians, cultural anthropologists, sociologists, and psychologists, a new National Academy of Religion and Mental Health has opened offices in the New York Academy of Medicine, 2 East 103rd Street, New York 29. Kenneth E. Appel, M.D., president of the Joint Commission on Mental Illness and Health, professor of psychiatry at the University of Pennsylvania and past president of the American Psychiatric Association, has been elected president.

The academy, a non-profit organization engaged in research and education in all relationships between religion and health, especially mental health, has been organized on an interfaith and multidisciplinary basis. Close working relationships have been established with Roman Catholic, Jewish and Protestant theologians and psychologically trained clergymen, some of whom are serving on an advisory council.

The academy expects to sponsor scientific research in relationships between religion and mental health; sponsor conferences between theologians, psychiatrists and others professionally engaged in mental health; stimulate local conferences; obtain fellowships, scholarships and grants-in-aid for clergymen of all faiths desiring graduate and clinical training in pastoral psychology and mental health concepts; interpret theological doctrines and attitudes to mental health workers; circulate a lending library; sponsor pilot courses of psychological instruction in certain seminaries of the three major faiths; publish

a monthly newsletter; prepare pamphlets and articles; serve as a resource center for information regarding relationships between religion and mental health; and provide consultative and advisory services.

No other organization of this kind has been established either in this country or elsewhere. The academy has been elected a member of the World Federation for Mental Health. Memberships in the academy are being solicited from professional workers and interested laymen.

The research committee includes John M. Cotton, M.D., director of psychiatry at St. Luke's Hospital, New York; Harvey J. Tompkins, M.D., director of the Jacob R. Reiss Mental Health Pavilion, St. Vincent's Hospital, New York; Nolan C. S. Lewis, M.D., director of research at the N. J. Neuro Psychiatric Institute, Princeton, N. J.; and Earl A. Loomis, Jr., M.D., professor of psychiatry and religion at Union Theological Seminary, New York. The educational committee includes the Rev. William C. Bier, S.J., associate professor of psychology at Fordham University, New York; the Rev. Otis R. Rice, D.D., religious director at St. Luke's Hospital, New York; the Rev. Sankey L. Blanton, D.D., president of Crozer Baptist Seminary, Chester, Pa.

Inquiries concerning the academy should be made to the Rev. George C. Anderson, director.

Another example of the growing interaction between psychiatry and religion is the establishment of a department of psychiatry in the Jewish Theological Seminary of America to acquaint "future rabbis with certain problems of the individual and the community as viewed by modern psychiatry." Fifteen teaching sessions presided over by psychiatrists will help the rabbi develop awareness of the psychological needs of his congregants, especially the young people, and also assist him in distinguishing between normal temporary emotional stress and mental illness. The psychiatric faculty, all members of the New York Institute of Psychoanalysis, described the purpose and content of the training course as the teaching of "moral dynamic psychology, i.e., an understanding of moral behavior, as well as the recognition of mental illness and the principles of conflicts."

A recent questionnaire poll of clergymen of all faiths in the western states, Hawaii, and Alaska, reveals that a majority of them favor closer working ties with the mental health professions in meeting community mental health needs. It was also brought out that a preponderant number of pastors spend about one-fourth of their working hours dealing with emotional problems of church members. These disclosures, announced by the California State Department of Mental Hygiene, appeared in a report on a western mental health training

and research survey supported by the U. S. Public Health Service. The survey showed that clergymen generally feel that increased availability of psychiatrists and clinical psychologists plus fuller training in these fields for religious leaders could be of definite value to the clergyman's present role of marriage counselor, youth leader, and guide to the needy, ill, and emotionally distressed. Several respondents pointed to the need for better liaison between the mental hospital and the clergymen following the release of mental patients. The clergyman, they noted, if contacted upon the release of a hospital patient, can do much in follow-up efforts to assist the convalescent person in regaining a useful role in his community.

Significant Meetings

The ninth annual meeting of the World Federation for Mental Health will be held in West Berlin, German, from August 12 to 17, 1956.

The theme of the meeting will be "Mental Health in Home and School."

The program will include plenary sessions, discussion groups, a special film group, technical sections, film sessions open to all participants, and the general session of WFMH, at which the new president will take office and elections for new officers and members of the executive board will be held.

The topics proposed for the plenary sessions include: the concepts of mental health and its international implications; a study of the relations between the mother and the new-born child; the mental health of the pre-school child and his family; the mental health of child, family, and school at the time of school entry; problems of change of environment and school; the provision of psychological services for pre-school and school children; the needs of sub-normal and highly gifted children; the recognition and treatment of difficulties in school; and mental health problems at the time of leaving school.

A number of participants will be able to join small informal discussion groups. For others there will be technical sections, at which one or two short papers will be presented on matters of medical, educational, and social interest in relation to mental health, which will then be the subject of general discussion.

The National Council on the Psychological Aspects of Disability will hold its annual meeting August 30 and 31 in Chicago in connection with the convention of the American Psychological Association. One session will be devoted to "Realistic Vocational Counseling in

Rehabilitation," another to "Psychological Implications of the Educational Management of Handicapped Children."

The psychological interpretation of children's behavior in various cultures will be the theme of meetings of the International Council of Women Psychologists at the Sherman Hotel in Chicago August 31, in connection with the convention of the American Psychological Association. This theme will be discussed at a luncheon meeting by Miss A. Elizabeth Adams of Surrey, England. Dr. Otto Klineberg will discuss "Problems Raised by the Application of Psychoanalytic Concepts to Children in Various Cultures."

The 14th annual meeting of the American Psychosomatic Society will be held May 4 and 5, 1957, at the Chalfonte-Haddon Hall Hotel in Atlantic City. Dr. I. Arthur Mirsky is president, Dr. Theodore Lidz is president-elect, and Dr. Morton F. Reiser is secretary-treasurer. New members of the council are Drs. Louis Linn, Eugene Meyer, Eric D. Wittkower and Harold G. Wolff.

Named Chairman of Forum on Mental Health

Dr. Francis J. Braceland, psychiatrist-in-chief of the Institute of Living in Hartford, Conn., and president of the American Psychiatric Association, has been appointed chairman of the 1957 National Health Forum Committee by Dr. Leona Baumgartner, president of the National Health Council and health commissioner of New York City. The 1957 Forum, one of an annual series conducted by the Council in the interests of its 51 national organization members, will focus on fostering mental health in America with emphasis on constructive actions and attitudes that may be taken by all health organizations. The Forum will be held in Cincinnati, March 20 and 21.

"Nine million Americans are suffering from mental illness serious enough to warrant treatment," said Dr. Baumgartner, "and half of our hospital beds are occupied by mental patients. Those facts point to a problem of national emergency proportions. Everyone can and must assume some share of responsibility for the preservation and promotion of mental health."

She said that she had asked Dr. Braceland to take the committee chairmanship partly because of his striking achievements at the Hartford Institute in returning the mentally ill to normal living.

"In addition," said Dr. Baumgartner, "Dr. Braceland, through his writing and speaking, is leading new efforts to bring sound psychiatric principles to bear upon everyday living through which we may hope to reduce the stresses of modern civilization that seem to lead to mental illness."

Dr. Braceland met June 4 with the nucleus of his committee. In addition to Richard P. Swigart, executive director, National Associa-

tion for Mental Health, members then included: Raymond H. Barrows, executive director, National Foundation for Infantile Paralysis, and chairman, NHC Forum Planning Committee; Richard C. Bostwick, Smith, Kline and French Laboratories; Robert H. Felix, M.D., director, National Institute of Mental Health; E. M. Gruenberg, M.D., Milbank Memorial Fund; Paul V. Lemkau, M.D., director, New York City Community Mental Health Board; Hildegard E. Peplau, R.N., Ed.D., director of the program in advanced psychiatric nursing of Rutgers University; R. J. Plunkett, M.D., Joint Commission on Mental Illness and Health; John D. Porterfield, M.D., director, Ohio State Department of Mental Hygiene and Correction; Mildred C. Scoville, treasurer of the World Federation for Mental Health; Irving S. Shapiro, Ph.D., assistant director of preventive medicine and health education, Health Insurance Plan of Greater New York; Sidney Spector, director, Interstate Clearing House on Mental Health, Council of State Governments; Dr. George D. Stoddard, chairman of the directing committee, New York University Self Study, and dean-elect of the School of Education.

Others will be invited to join the committee, which will hold another summer meeting.

Stress Significance of Family Relationships

The importance of the family unit in mental health was a recurring theme throughout the thirty-third annual meeting of the American Orthopsychiatric Association in New York, March 15 to 17. Sessions were attended by nearly 5,000 psychiatrists, psychologists, psychiatric social workers, and others interested in community mental health, psychiatric treatment, and institutional administration.

Luther E. Woodward, Ph.D., senior community mental health representative for the New York State Department of Mental Hygiene, was installed as president at the conclusion of the meeting, succeeding Dr. Exie E. Welsch, child psychiatrist and associate in psychiatry, College of Physicians and Surgeons, Columbia University. Other officers for 1956–7 are president-elect, Reginald S. Lourie, M.D., director of the department of psychiatry, Children's Hospital, Washington, D. C.; vice-president, Theodora M. Abel, Ph.D., director of psychology, Postgraduate Center of Psychotherapy, New York, and adjunct professor of psychology, Long Island University; and treasurer, S. Harcourt Peppard, M.D., director of the Essex County Guidance Center, East Orange, N. J.

A resolution passed at the final session placed the association on record as officially in favor of attempts to achieve "effective, psychologically sound, and lawful transition from segregated to nonsegregated public schools" on the basis that "research findings, clini-

cal studies, and general observation indicate that racial segregation, discrimination, and arbitrary prejudices damage and distort the personality of children" and that "a racially non-segregated society will be conducive to the good mental health and well-being of the entire nation."

Dr. Abram Kardiner, dean of the Psychoanalytic Clinic at Columbia University, told a session on orthopsychiatry and prevention that today's mental problems are related to the fact that the home has been "culturally invaded" by the mass media, with the result that the parental role in "cultivation of the social emotions" of children has been usurped. A related problem, he said, is that we are living in an age of anxiety because "there is an ever-widening gap between what we have, in terms of physical comforts, and what we want."

Other papers emphasizing the family unit included one by Joseph Weinreb, M.D., director of the Worcester (Mass.) Child Guidance Clinic, on the dynamics of direct consultation to parents of disturbed children emphasizing the importance of "helping the parent in a dynamic way without depriving him of his status as a parent."

Another session on therapy with parents included a paper by Leon Eisenberg, M.D., of the Johns Hopkins Hospital, Baltimore, on a study of 100 autistic children showing that distorted paternal attitudes "emerge as prominent features but do not conform to a single stereotype." Three staff members of the Guidance Center of Buffalo—David Hallowitz, Robert G. Clement, and Albert V. Cutter, M.D.—described five years' experience in treating both parents together and concluded that "there is enormous potential in this process in terms of getting at the deeper sources of a child's emotional disturbance." A paper by David Limentani, M.D., Eveoleen N. Rexford, M.D., and Maxwell Schleifer, Ph.D., all of the Douglas A. Thom Clinic for Children, Boston, suggested that inadequate knowledge of the father and infrequent treatment for him is a common factor in treatment failures. A workshop session also was devoted to problems of family diagnosis.

In her presidential address, Dr. Welsch reaffirmed the fundamental principles of orthopsychiatry as "a central concern with the individual, but with focus on the multiple factors of a person's living in a search for more comprehensive understanding of human behavior," and the utilization of a team including non-medical members with specialized skills, among them the psychologist and psychiatric social worker, "because the nature of personality requires a team structure to serve it adequately and comprehensively."

Albert Deutsch, writer on mental health subjects, pointed out that despite increased public interest in mental illness, "our mental institutions remain for the most part overcrowded, understaffed, ill-equipped; the long waiting-lists for child guidance clinics and other

outpatient services attest to the great volume of frustration; we are desperately short of psychiatrists, psychologists, social workers, nurses, and other mental health personnel—short of everything but patients."

Ira deA. Reid, Ph.D., professor and chairman of the department of sociology, Haverford College, analyzed mental health aspects of segregation and desegregation and stressed the need for greater understanding of sub-groups and multi-group relationships.

Other topics of major interest included juvenile delinquency, psychiatric treatment of children, psychiatric clinic practices and procedures, community mental health, and mental health services in schools.

Hold Forum on Anxiety and Tension

Insecurity, fear and dissatisfaction throughout the world take a staggering toll in human health and happiness, a panel of top authorities emphasized at the First Annual Forum on Anxiety and Tension April 30 in New York City.

The forum, opening Mental Health Week, analyzed international, racial, labor-management and individual tensions. It was sponsored by CIBA Pharmaceutical Products in cooperation with the National Association for Mental Health.

Opening the conference, F. Barry Ryan, Jr., NAMH president, pointed out that the tensions which make it difficult for the individual human being to live at peace with himself also make it difficult for groups of human beings to live at peace with each other. Noting that no group of sick people has been so neglected as the mentally ill, Mr. Ryan called for research to find and eliminate the causes of mental and emotional disorders.

He also read a telegram from President Eisenhower: "Please extend my greetings to those participating in the forthcoming Annual Forum on Anxiety and Tension. During Mental Health Week, a time when we are all asked to put forth a united effort to improve the lot of the mentally ill, it is fitting that you search out and discuss together some of the basic factors that undermine mental health. I extend to all of you my best wishes for a successful series of deliberations."

"Some researchers," Dr. Kenneth E. Appel, NAMH board member, told the audience, "believe that emotional factors play a role in cancer, infectious diseases and accidents. If this is true, dissatisfaction is a prime mover in all the principal causes of death." The mental health movement, he added, must help every physician and citizen to realize that satisfaction is essential to health.

Dr. Harvey J. Tompkins, chairman of the NAMH professional advisory committee, reported that an increasing number of mental patients who previously would require hospitalization now are being treated effectively at home, in the physician's office or in an outpatient

clinic. But if we are to reduce the number of hospitalized psychiatric patients to a minimum, there is need, he said, for a greater acceptance of responsibility by the ordinary citizen.

Other speakers were Mrs. Eleanor Roosevelt, Sen. Michael J. Mansfield of Montana, Rep. Walter H. Judd of Minnesota, James B. Carey, president of the International Union of Electrical, Radio and Machine Workers (AFL-CIO), Patrick B. McGinnis, president of the Boston & Maine Railroad, Dr. Channing Tobias, chairman of the board of the National Association for the Advancement of Colored People, Clark M. Eichelberger, executive director of the American Association for the United Nations, T. F. Davies Haines, CIBA president, and Dr. Margaret Mead, eminent anthropologist and forum chairman.

Publications

Nearly 2,000 psychiatric clinics and other services for the mentally ill are listed in the eleventh edition of a directory of mental health resources in the United States and territories, published in June by the National Association for Mental Health.

The directory supplies information on over 1,200 regularly scheduled full-time and part-time outpatient psychiatric services, scores of state hospitals and institutions for the mentally ill, mentally defective and epileptic, Veterans Administration hospitals, state departments dealing with mental health, and 500 state and local mental health associations.

The information was compiled jointly by the National Association for Mental Health and the National Institute of Mental Health of the U. S. Public Health Service. In a foreword Dr. R. H. Felix, NIMH director, and Dr. George S. Stevenson, NAMH consultant, point out that the directory will be a useful reference book for professional personnel "in whatever capacity they serve the individual and the community."

The co-sponsors emphasize that the directory should also stimulate "a united effort to develop greater public understanding of mental health problems and informed citizen action." They note that the organization of many more mental health associations—now being undertaken by field workers of the National Association for Mental Health—will give the public "a medium through which to channel interest and support for mental health services of all types."

The directory lists psychiatric clinics by location, and gives details of sponsorship, geographic area of service, special groups served, age limitations on patients, clinic schedules, and number and type of professional staffs.

The co-sponsors emphasize that they have made no attempt to appraise the work of the clinics listed. "The directory is not to be

regarded in any sense as an accredited list of clinics," they caution, "and no endorsement of a particular clinic is implied by including it."

Although additional outpatient clinics and improved mental hospitals are needed, according to Dr. Felix and Dr. Stevenson, acute shortage of mental health personnel will slow the growth of psychiatric services for years to come.

The directory is available from state mental health associations and from the headquarters of the National Association for Mental Health, 1790 Broadway, New York City, for $1.50, with special prices for quantity orders.

The Committee on Publications of Washington University has announced the publication of a new book in the Washington University Studies series, *Theory and Treatment of the Psychoses: Some Newer Aspects.*

The book contains addresses delivered at the dedication of the Renard Hospital, St. Louis: "Psychiatry in the General Hospital," Alan Gregg, M.D.; "A Psychiatrist Looks at Psychiatry," Stanley Cobb, M.D.; "Theoretical Contribution to the Concept of Milieu Therapy," Alfred M. Stanton, M.D.; "Strategy and Tactics in Psychiatric Therapy," John C. Whitehorn, M.D.; "Some Sociological Aspects of the Psychoses," F. D. Redlich, M.D.; "What Is Psychotic Behavior?", B. F. Skinner, Ph.D.; "Major Themes," George Saslow, M.D.; "Historical Note," Edwin F. Gildea, M.D., and Margaret C.-L. Gildea, M.D.

Orders may be placed through the Committee on Publications, Washington University, St. Louis 5, Mo., at $2.00 per copy.

A new pamphlet, "Pastoral Help in Serious Mental Illness," will be made available this month for use by clergymen of all faiths.

The pamphlet, produced by the National Association for Mental Health, is the third of a special series designed to give the clergy an understanding of psychiatric disorders and their effects on the patient, his family and the community. It was written by the Rev. Henry H. Wiesbauer, Protestant chaplain of Westborough (Mass.) State Hospital and rector of St. Paul's Episcopal Church, Hopkinton, Mass.

Noting that the clergyman is often the first person to whom a mentally ill individual or his family turns for help, the 12-page pamphlet tells the minister how to recognize a psychotic parishioner and refer him to appropriate community resources. It also suggests ways in which the minister can cooperate effectively with the psychiatrist and with the patient's family before, during and after hospitalization.

Earlier pamphlets in the series are "The Clergy and Mental Health," which emphasizes the extent of mental illness and suggests

ways in which a clergyman can serve the mental health needs of his congregation and community, and "Ministering to Families of the Mentally Ill," for clergymen and everyone professionally concerned with the need for counseling families of the mentally ill.

Other educational services provided by the National Association for Mental Health and its affiliated state and local associations to clergymen and church groups are suggestions for sermons on mental health topics, information on mental diseases and common emotional problems, workshops and institutes on religion and mental health, and mental health films, filmstrips, dramatic sketches and other audio-visual aids.

The new pamphlet is available to the general public for 10¢ a copy, with special rates for quantity lots.

A tremendous unfilled demand for trained social workers exists throughout the nation, asserts Lucy Freeman in *Better Human Relations—The Challenge of Social Work,* a pamphlet published recently by the Public Affairs Committee. "At least 50,000 additional recruits will be needed in the next decade," according to an estimate of the Council on Social Work Education, which cooperated in the preparation of the pamphlet. "For those who have the requisite professional education, social work offers a tremendous opportunity for service. Severe shortages exist throughout the country," it points out.

"Most people face, at some time in their lives, a situation in which they must depend on someone else for help," Miss Freeman declares. "But the kind of help that people need varies widely. They may . . . need help in their relations with other people. Or they may need help in meeting the problems of the world about them, in earning a living, or in meeting sickness or disaster. Most of the problems are complex. They combine environmental strain and emotional stress—and each makes the other more difficult.

"One of the tasks of the social workers," Miss Freeman continues, "is to help the individual determine the nature of his need and how it can be met. Frequently the skill of the social workers makes it possible to give the individual asking help sufficient insight into his problem so that he can follow a course of action mutually agreed upon.

"Concern for people and a desire to help them are prerequisites for anyone entering the social work field," the author continues. "But the social worker of today needs more than these qualities of heart and mind. If he is to help people meet their problems, he must be thoroughly trained for this responsibility. This involves specialized education.

"Even without full professional education, many social workers are

doing a fine job," Miss Freeman concedes. "But the public, more and more, is demanding that the personnel in this basic professional field be professionally prepared. The problems encountered in the practice of social work today call for something beyond the native capacities of even the most gifted. Professional skills, professional attitudes, professional knowledge are needed.

"The professional training of the social worker is designed to help him understand people and the causes of their problems through a scientific knowledge about human behavior and society," she adds. "Social work is both a science and an art in human relations."

The pamphlet is available from the Public Affairs Committee, 22 E. 38th St., New York City, for 25¢ a copy.

The first issue of the Mental Health Book Review Index, which will be published semi-annually, is now available without charge to librarians who have long been seeking this kind of periodical assistance in an important area of interest. The new publication indexes reviews of books on psychology, psychiatry, psychoanalysis, and related subjects, appearing in fifty journals. Created and edited by the subcommittee on book appraisal of the Adult Education Board of the American Library Association, the index is available as a supplement to Vol. VII, No. 3, Jan.-Feb. 1956 of the Psychological Newsletter.

Communications concerning the index should be addressed to Miss Lois Afflerbach, Paul Klapper Library, Queens College, Flushing, L. I.